Program Overview

How to Complete this Application:

1. Review the information on this page carefully and keep it for your records.
2. Complete pages 3, 4 and 5 of the application.
3. Gather the required documentation listed on page 2.
4. Mail or fax your completed application and required documentation following the instructions on the next page.

What is the TerSera Patient Assistance Program?

The TerSera Patient Assistance Program (the Program) allows you to get free medicines if you qualify. It is neither a government program nor an insurance plan

- If you qualify, you may get free TerSera medicine for up to 1 year. TerSera will send you an application for renewal once your enrollment ends
- Medicines can either be sent to your home or to your doctor's office
- Most medicines are sent in a 90-day supply

The Program can be changed or stopped by TerSera at any time or for any reason.

Do you qualify for the Program?

You may qualify for the Program if:

- You are a US Resident, or a Green Card or Work Visa holder
- You meet certain household income limits (call 1-855-686-8725 for details)
- You do not have prescription drug coverage that helps pay for your TerSera medicines

The Affordable Care Act has created a marketplace of Health Insurance Exchanges where uninsured individuals and families are able to purchase healthcare coverage, the cost of which may be subsidized for qualified enrollees. More information about these plans can be found at www.healthcare.gov.

Please review the checklist on the next page to ensure that your application is complete and ready for submission.

Program Application Checklist

The following items must be submitted by mail or by fax to complete your application, even if you have completed the application online. Keep this page for your records.

Send ALL the following TOGETHER:

☐ A completed application, signed and dated by you and your prescriber
(blank applications can be found on azandmeapp.com)

☐ The completed prescription on page 3 of this application

☐ Proof of household income (include only **one** of the following):

- A copy of last year's federal income tax returns for yourself, spouse, and dependents
- All income statements from jobs last year (W2 or 1099)
- Two current paystubs
- Current Social Security Income Yearly Benefits Statement
- **If current household income is zero**, a letter explaining your financial situation from a family member, healthcare provider, or yourself

Please do not send your medical records or Statement of Medical Necessity form with your application.

MAIL your completed application, prescription, and required proof of income documentation to:

TerSera Patient Assistance Program
PO Box 46
Somerville, NJ 08876

Or

Your doctor's office may FAX your completed application, prescription and required documentation, with a fax cover sheet to **1-855-836-3066**. **Applications and prescriptions not faxed from the doctor's office will be deemed invalid.**

Important Information about your Application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

For Prescription Refills, call 1-855-686-8725

Once you are enrolled in the Program, your prescriptions can easily be refilled by calling our automated phone line 24 hours a day, 7 days a week.

Prescription Information

PATIENT INFORMATION: *Please print clearly in **blue or black** ink.*

Social Security Number:_____-_____-_____ Date of Birth:_____/_____/_____

(This information will only be used to determine eligibility.) *(MM/DD/YYYY)*

Name: _____

First *Middle Initial* *Last*

Address:_____ City:_____ State:_____ Zip: _____

☐ Patient has no current address. (Medication will be shipped to HCP's office)

Phone: (_____)_____ Alternate Phone: (_____)_____ E-mail: _____

☐ New Application ☐ Re-enrollment

PRESCRIBER INFORMATION:

This form will replace all previous prescriptions that may have been sent. <u>All fields are required</u>.
e.g., BRAND NAME, strength, directions for use, quantity, and refills

Prescriber Name:_____ Phone: (_____)_____ Fax: (_____) _____

Address: _____ City: _____ State:_____ Zip: _____

DEA: _____ NPI:_____ State License Number (SLN): _____

Office Contact Name:_____ Phone: (_____) _____

Medication/Strength:	Directions:	QTY:	Refills:

SHIP MEDICATION TO: ☐ **PATIENT** ☐ **PRESCRIBER***

*(*For Prescribers in Ohio ONLY: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station)*

Prescriber Signature: _____ Date: _____

NY Prescribers must attach a separate prescription in accordance with NY pharmacy law.

Source ID: _____

Please fax completed forms including signature to: 1- 855-836-3066

Program Eligibility Information:

Please print clearly in blue or black ink.

Name: _____ Social Security Number: _____-_____-_____

First *Middle Initial* *Last*

If you don't have a Social Security Number you must provide one of the following:

☐ Green Card (Please provide number):_____ ☐ Work Visa (Please provide number): _____

Primary language spoken: ☐ English ☐ Spanish ☐ Other:_____

Marital status: ☐ Married ☐ Divorced ☐ Single Widow/Widower

Disabled (approved by Social Security): Yes No

INCOME:

What is the total combined household income before taxes? *(Include yourself, all adults, and all dependents)*

Note: You will need to provide proof of income with your application.

$_____Monthly O R $_____Yearly

Number of people in your household:_____Number of dependents in your household:_____

(Include yourself, all adults, and all dependents)

INSURANCE:

Do you have any form of prescription drug coverage? ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Employer-furnished or private drug coverage

☐ VA or Military Benefits ☐ Other Prescription Coverage _____

☐ Medicare Part A (hospital) ☐ Medicaid State Assistance program for medicines

☐ Medicare Part B (medical)

☐ Medicare Part D (prescriptions)

☐ Extra Help/Limited Income Subsidy

Please fax completed forms including signature to: 1- 855-836-3066

Patient Consent

I GIVE my doctor, TerSera Therapeutics LLC (TerSera), and the Program administrator and their employees, agents, and contractors permission to verify my information to make sure it is true and complete; contact me about the Program and about other products, programs, or services that might interest me or for which I may be eligible; and contact me to ensure that I have received the medicines sent by the Program.

I PROMISE that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines; and I will contact the Program if any of my information about my prescription drug coverage or insurance changes.

I UNDERSTAND that the Program will only use my information to decide if I qualify to participate in the Program; administer or improve the Program; and/or communicate with insurance plans.

I UNDERSTAND that I can call 1-855-686-8725 at any time to withdraw from the Program; cancel my permission to use my information and withdraw from the Program; and/or get a copy of the TerSera Privacy Statement.

I UNDERSTAND that the Program can request more information from me at any time; and TerSera can change or stop the Program at any time or for any reason.

I UNDERSTAND that once my information has been disclosed to my doctor, federal privacy laws may no longer restrict its use or disclosure, but the Program will only use my information as described in this form.

I MAY refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program.

I GIVE the Program, and the Program administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you).

This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

Signature of Applicant or Legal Guardian

X_____ **Date:** _____/_____/_____

(MM/DD/YYYY)

Patient Name (Please Print)**:**

_____

Prescriber Name: _____ **Prescriber Phone: (**_____**)** _____

If someone helped you with this application and you want them to answer questions for you, please give us their name and phone number:

Helper's Name: _____ **Helper's Phone: (**_____**)** _____

Questions? Call **1-855-686-8725**

Please fax completed forms including signature to: 1- 855-836-3066