Boehringer Ingelheim Cares Foundation

BI Cares Foundation Patient Assistance Program- Ofev®

P.O. Box 5637, Louisville, KY 40255
Phone: 1-855-297-5906
Hours: M-F, 8:30a – 6:00p ET
Fax: 1-855-297-5907

The Boehringer Ingelheim Cares Foundation (BI Cares) Patient Assistance Program (the "Program") is free of charge to eligible US patients who apply to and are enrolled in the Program.

Please Note: The Boehringer Ingelheim Cares Foundation, Inc. is not affiliated with any third-party individual or organization that may charge patients a fee(s) to assist them in applying to our Program or ordering refills through our Program. These individuals or organizations are acting independently of the Boehringer Ingelheim Cares Foundation and do not have our Foundation's consent.

Who is eligible?

All applications are reviewed in accordance with BI Cares Program eligibility criteria. To be eligible, you must:

- ❑ Be a resident with a physical address within the United States or US Territory
- ❑ Have one of the insurance coverage circumstances outlined below:
  - No health coverage
  - Not enough coverage to obtain the medication Ofev®
- ❑ Not have access to alternate sources of coverage or funding for your Ofev®
- ❑ Meet household income guidelines established by BI Cares

What information is needed to submit an application?

The following items should be submitted to the BI Cares Patient Assistance Program for the application to be considered complete:

- ❑ Complete Sections 1-4 including signatures, including the Patient Authorization to Share Health Information (page 3)
- ❑ Have a Healthcare Provider complete Sections 5-7 including an original signature
- ❑ Proof of income is required (See Section 2 for more information)

Section 1: Patient Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

***Note**: Delivery will be to patient's address unless otherwise indicated by the patient.*

Preferred Daytime Phone Number *: ( ) –

* I understand this Program may include calls and emails from BI Cares Foundation and its third-party partners ("Partners"). These periodic communications are intended to provide timely updates regarding the status of your application and other information related to your participation in the Program. By answering "YES" below, you indicate that you would like to receive support via texts as well.

Please Send me Text Notifications on Program & Shipment Statuses: Yes No

***YES,** I agree to receive periodic messages from BI Cares Foundation and its Partners about my participation in the Program and other related information at the telephone number provided below. I understand texts may be sent via an autodialer and are not a condition of enrollment in the Program. Standard message and data rates may apply.*

Please provide the preferred phone number for text notifications: ( ) –

Date of Birth (MM/DD/YYYY): / /

Gender (Please Circle): Male Female

Preferred Language (Please Circle): English Spanish Other: _____

Section 2: Patient Financial Information

How many people live in your household (including yourself)? _____

What is the total household income for a year? $ _____

Total patient household assets (Include 401(k), second home, IRA, etc. Do not include primary home or car)) $ _____

Please include proof of income for ALL members of the household:
Preferred Financial Documentation: IRS Forms 1040, 1040EZ, 1040X, 1099 or copies of all W-2 forms for the Household

- Other acceptable forms of Financial Documentation: SSA-1099, Social Security Benefits Statement, one month of Paycheck stubs dated within the last 90 days, Alimony Statements, Pension Statements or Railroad Retirement Statements
- I understand that any product provided to me through BI Cares is contingent upon my meeting eligibility criteria; and that BI Cares reserves the right to make an independent determination of financial and medical need.

Patient / Authorized Rep. Signature:	**Date:**

First Name: _____ Last Name: _____

Section 3: Insurance Information

	circle one	
Have you received disability payments from Social Security for more than 24 months?	Yes	No
Have you received a denial letter from Medicare Low Income Subsidy? *If yes, please attach a recent copy of this letter along with your application.*	Yes	No
Do you have Medicare Part D or Medicare Advantage?	Yes	No
Do you have Medicaid?	Yes	No
Do you have prescription drug coverage from a commercial or private health insurer? (Not including Medicare Part D prescription benefits)	Yes	No
Do you receive Veterans Affairs prescription drug coverage benefits?	Yes	No

Section 4: Patient Attestation

By signing the below, you, the Patient, attest and certify that:

- The information provided in this application and any additional information provided as a part of the application process is current, complete and accurate to the best of your knowledge.
- You cannot afford the medication requested and: (1) have no coverage; (2) have no coverage for the medication for which you've applied for support under the Program; or (3) have coverage for the medication but have an out-of-pocket expense you cannot afford.
- You will not seek reimbursement from any insurer or government program for any medication dispensed from the Program and you will immediately notify the Program if the medication requested is/are no longer medically necessary or if your insurance/financial status has changed.

In addition, by signing the below, you, the Patient, understand and agree that:

- Any medication supplied as a result of this Application is for your use only, and shall not be sold, traded, bartered, transferred or returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to you.
- The information provided in this Application is subject to random audits and verification. During such audits and verification processes, you may be asked for additional supporting documentation.
- BI Cares may change this Program at any time and reserves the right to terminate your enrollment at any time due to lack of eligibility or related factors.
- The medication made available to you under this Program may be denied if you do not fully cooperate with efforts made to verify the information provided in this application, or if you do not take steps to secure other forms of payment for your medication after being notified of other programs for which you may be eligible.

BI Cares is not obligated to verify any of the information contained in this Application or to confirm other medications that you are taking.

By signing below, I give my permission to share my personal information with Boehringer Ingelheim Cares Foundation, Inc., its representatives, agents, and other third-party partners supporting the administration of the Program, who may contact me with follow-up inquiries and who may report my personal information to health authorities to comply with applicable rules and regulations.

Patient / Authorized Rep. Signature:	**Date:**

Patient Authorization to Share Health Information

First Name: _____ Last Name: _____

By signing the below, I give my permission to my healthcare practitioners, pharmacy providers, health plan, and insurers to share my personal and health information with BI Cares, its representatives, agents, and other third-party partners supporting the administration of the Program (collectively, "BI Cares and its Partners"). I understand my personal and health information may include, but not be limited to, my medical condition, treatment, care management, health insurance, medication history, and prescriptions (the "Information").

I give BI Cares and its Partners authorization to use and further disclose the Information for the following purposes:

- To process my application for the Program, validate the information provided in this application, and verify my eligibility for participation in the Program, investigate and verify my insurance benefits and/or identify other patient assistance resources.
- To notify me if I do not meet the eligibility requirements or if there are any changes to the Program.
- If eligibility is confirmed, to facilitate my participation in the Program, which will include the dispensing and delivery of medication.
- To assist in the general administration of the Program and conduct any additional services described above and related to the Program.
- To comply with applicable rules and regulatory requirements related to safety information received in the course of administering the Program, where such information is collected in the interest of patient safety. Such information will be filed in a global database and the information may be reported to regulatory authorities. Boehringer Ingelheim will retain the data as long as required by applicable rules and regulations.

Without limiting the purposes for the use and disclosure of the Information set forth above, I understand:

- BI Cares and its Partners respects your privacy and implements safeguards in an effort to keep the Information confidential, but the Information released under this authorization may no longer be protected by state and federal privacy laws and that the Information may be lawfully re-disclosed by recipients.
- That I may cancel this authorization at any time by giving written notice to BI Cares at the address noted on this application, but my cancellation will only apply to future use of the Information and not change any actions taken before my canceling.
- That I have a right to receive a copy of this authorization from my healthcare practitioner and/or BI Cares, and that I may inspect/obtain a copy of the Information disclosed pursuant to this authorization.
- That I can refuse to sign this authorization and it will not impact the way my healthcare practitioners, pharmacy providers, health plan, and insurers treat me, but if I do not sign this authorization, I will not be able to participate in the Program.
- This authorization is valid from the date of its execution and will expire one year from the date of enrollment in the Program or the date I am notified I am ineligible for the Program, unless I revoke my consent per the terms of this authorization.

Patient / Authorized Rep. Signature:	**Date:**

Fax the Complete Application: 1-855-297-5907
Phone: 1-855-297-5906

Section 5: Prescriber Information

Prescriber Name: _____ NPI: _____

Specialty: _____ SLN #: _____ SLN Exp. Date: _____

Site/ Facility Name: _____ Office Contact Name: _____

Address _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Section 6: Prescription & Medication Information*

First Name: _____ Last Name: _____ Date of Birth: ___/___/___

Ofev® (circle one): 100mg 150mg Days Supply: 90 days

Directions: _____ Refills (circle one): 1 2 3

Medication Allergies? Yes No If Yes, please list all drug allergies: _____

Current Medications (please list): _____

** A separate prescription form may be attached to this application and a separate form should be attached if required by federal and state law.*

The information you, the Prescriber, provides as part of this BI Cares Patient Assistance Program – Ofev® application ("Application") will be used by Boehringer Ingelheim Cares Foundation, Inc. ("BI Cares") and its affiliates, agents, representatives and service providers to (1) process this Application and verify the information contained in this Application, (2) administer, analyze, and improve the BI Cares Patient Assistance Program ("Program"), (3) improve and tailor our products and services to better serve you, (4) communicate with you about your experience with the Program, and/or (5) send you materials and other helpful information and updates relating to BI Cares programs ("Services").

By signing below, you, the Prescriber, attest and certify that:

- The information provided in this Application and any additional information provided as part of the Application process is current, complete, and accurate to the best of your knowledge.
- To the best of your knowledge, the patient identified in this Application cannot afford the medication requested and (1) has no coverage or (2) has no coverage for the medication or (3) has coverage for the medication but has an out-of-pocket expense he/she cannot afford.
- You will not seek reimbursement for any medication dispensed from the Program.
- You will notify the Program immediately if the medication requested is no longer medically necessary for this patient's treatment or if you become aware that your patient's insurance or financial status has changed.
- You have a signed copy on file of your patient's current and completed HIPAA Authorization, or any other authorization or consent required by law, so that you may share patient health information with the Program, including BI Cares and its affiliates, agents, representatives and service providers.

In addition, by signing below, you, the Prescriber, understand and agree that:

- Any medication supplied as a result of this Application is for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred or returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to your patient.
- The information provided in this Application is subject to random audits and verification.
- BI Cares may change this Program at any time and reserves the right to terminate your patient's enrollment at any time due to lack of eligibility or related factors.

Prescriber Signature: (Original – Stamps NOT ACCEPTED)	**Date:**

Fax the Complete Application: 1-855-297-5907
Phone: 1-855-297-5906

Patient First Name: _____ Patient Last Name: _____

Prescriber Name: _____

Section 7: Other Coverage Information

If your patient has prescription coverage, the following information may be helpful in determining your patient's eligibility for the BI Cares Patient Assistance Program:

Name of Preferred Specialty or Dispensing Pharmacy: _____

Was the product covered by the patient's prescription drug coverage? (Please Circle):

Yes No N/A (Patient is Uninsured)

- Please provide the name of the prescription plan: _____
- *If No*, was a formulary exception or prior authorization submitted & denied? Yes No
  - *If Yes*, was an appeal submitted and denied? ..... Yes No