

Patient Assistance Program Application

FAX OR MAIL THE COMPLETED FORM TO NS SUPPORT PATIENT ASSISTANCE PROGRAM



888-212-0482



PO Box 7613, Overland Park, KS 66207-9941

Thank you for your interest in the NS Support Patient Assistance Program (“PAP”). The PAP is committed to helping uninsured patients in financial need receive free prescription medication. Patients must submit accurate and complete documentation to validate levels of income as requested below. Approved patients will be eligible to receive assistance for one year from the date your eligibility is approved.

Am I eligible for this free prescription program?

You may qualify for our free prescription program if you meet these requirements:

- You have been prescribed an NS Pharma medication
- Your income isn’t more than four times the Federal Poverty Level based on household size
- You don’t have health insurance
- You were denied coverage by Medicaid
- You aren’t covered by government health insurance, including Medicare, Medicaid, CHIP, TRICARE, Indian Health Service, Department of Defense, or other federal or state assistance programs
- You must be a citizen or a permanent resident of the US or its territories, and reside in the US or its territories
- You are being treated by a US licensed doctor as an outpatient

What information is required on the application form?

Your PAP application must include the following information:

PATIENT INFORMATION

- Complete the Patient Information (Section 1)
- Complete the Financial Information (Section 2), including all sources of household income and household size
- Sign Patient/Parent/Guardian/Legal Representative Authorization (Section 3)

PHYSICIAN INFORMATION

- Complete Physician Information (Section 4) and Prescription Information (Section 5). Provide phone, fax, and DEA, Tax ID or State License number
- Have Patient fully complete the Patient Information sections (Sections 1-3)
- Sign the Prescription Information section (Section 5)

Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM–8 PM ET.

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PLEASE COMPLETE ALL SECTIONS. By providing full information and signatures, you can help avoid processing delays.

1. PATIENT/PARENT/GUARDIAN /LEGAL REPRESENTATIVE INFORMATION

PATIENT FIRST NAME _____ PATIENT LAST NAME _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 DOB (MM/DD/YYYY) _____ GENDER (optional) Male Female
 PRIMARY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____
 PREFERRED PHONE # _____ EMAIL ADDRESS _____

2. FINANCIAL INFORMATION

List all household sources.

NUMBER OF PEOPLE IN HOUSEHOLD (include self) 1 2 3 4 5 6 7 8+

HAVE YOU RECEIVED DISABILITY PAYMENTS FROM SOCIAL SECURITY FOR MORE THAN 2 YEARS? Yes No

SALARY/WAGES \$ _____ ALIMONY/CHILD SUPPORT \$ _____ PENSION/RETIREMENT \$ _____
 DISABILITY \$ _____ SOCIAL SECURITY \$ _____ UNEMPLOYMENT \$ _____
 ANNUAL INCOME \$ _____ TOTAL YEARLY COMBINED HOUSEHOLD INCOME \$ _____

3. PATIENT/PARENT/GUARDIAN/LEGAL REPRESENTATIVE AUTHORIZATION

My (or my parent/guardian/legal representative's) signature below authorizes each of my physicians and pharmacists (including any specialty pharmacies and other healthcare providers) and each of my health insurers to use and disclose my Protected Health Information ("PHI"), including but not limited to medical records, information related to my medical condition and treatment, financial information, lab values, insurance coverage information, my name, address, and telephone number, to NS Pharma, Inc., and its agents, contractors, and assignees (together, "NS Pharma") to enroll me in and contact me (or my parent/guardian/legal representative) about NS Support, provide case management by mail, email, phone calls, detailed voice messages, interactive voice recordings that may include use of auto-dialers or artificial or prerecorded voice messages, and SMS text messages (data rates may apply) as explained in the Telephone Consumer Protection Act (TCPA) consent to assist with adherence to my medication regimen, and work with third parties to provide community resources and referrals. Third-party vendors, such as specialty pharmacies, may receive financial remuneration in exchange for data, product support services, reimbursement services, etc. This authorization expires 5 years from the date of execution, unless a shorter period is required by state law.

I understand that to qualify for PAP I must meet certain income and other eligibility requirements, and that NS Pharma uses credit bureau electronic income validation to help determine my eligibility but may ask for proof of income at any time for the purpose of eligibility or audit/verification. I understand that I may be required to provide proof of ineligibility for certain other prescription drug coverage or affordability programs to meet eligibility requirements for PAP.

I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits, including my access to therapy, is not conditioned on signing this authorization. I (or my parent/guardian/legal representative) understand that revoking this authorization will not affect the ability to use and disclose PHI received prior to receipt of notification that I (or my parent/guardian/legal representative) wish to discontinue my participation in the program. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may revoke this authorization at any time verbally at 833-NSSUPRT (833-677-8778) or in writing to NS Support at PO Box 7613, Overland Park, KS 66207-9941. Once authorization has been revoked or expired, I (or my parent/guardian/legal representative) understand that my future PHI will not be disclosed. I (or my parent/guardian/legal representative) understand that my PHI will not be used or disclosed for any other purposes, unless permitted by law, than for the purposes stated above. Information disclosed pursuant to this authorization or provided to a third party may no longer be protected by federal privacy laws. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) have a right to receive a copy of this authorization.

I attest that I am a citizen or a permanent resident of the US or its territories, and reside in the US or its territories.

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) SIGNATURE _____

DATE _____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) PRINT NAME _____

RELATIONSHIP TO PATIENT _____

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4. PRESCRIBER INFORMATION

PRESCRIBER FIRST NAME _____ PRESCRIBER LAST NAME _____
 FACILITY NAME _____
 ADDRESS _____ SUITE # _____ CITY _____ STATE _____ ZIP _____
 NPI # _____ STATE LICENSE # _____ TAX ID # _____ DEA ID # (Optional) _____
 OFFICE CONTACT _____ PHONE _____
 FAX _____ EMAIL _____

5. PRESCRIPTION FOR VILTEPSO® (VILTOLARSEN) INJECTION, FOR IV INFUSION

SPECIAL NOTE: Physician must comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, etc. Non-compliance with state-specific requirements could result in follow-up and delayed processing.



ePrescribe: ARx Patient Solutions Pharmacy, NCPDP #: 1720677

PATIENT FIRST NAME _____ PATIENT LAST NAME _____ DOB (MM/DD/YYYY) _____
 WEIGHT (kg) _____ PATIENT ALLERGIES _____
 CONCURRENT MEDICATION(S) _____

MEDICATION	TOTAL WEEKLY DOSE IN MG	DIRECTIONS	DAYS SUPPLY*	REFILLS*
VILTEPSO 250 mg/5 mL		Administer 80 mg/kg IV once weekly over 60 minutes. Combine with normal saline to a minimum volume of 100 mL.	28 days	

*For NS Support Patient Assistance Program, VILTEPSO is dispensed by ARx Patient Solutions Pharmacy. Program rules define the days supply and number of refills permitted.

SITE OF CARE/SHIP TO: Physician Office Hospital Outpatient Department Infusion Center/Clinic Home Infusion

SITE OF CARE NAME (Optional) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CONTACT FIRST NAME _____ CONTACT LAST NAME _____ PHONE _____ FAX _____

I request that the medication prescription written above be provided for the above-named patient who has demonstrated a medical need. To the best of my knowledge, my patient does not have affordable third-party coverage for this prescription through, for example, an HMO, Private Insurance, State Pharmacy Program, Medicaid, or CHIP. By signing this form, I authorize NS Support as my designated agent on behalf of my patients, to process the prescription and coordinate Product shipment as indicated on the Patient Start Form for VILTEPSO only for the specific patient identified. I also attest that I will not bill, charge, seek credit for or otherwise submit any claim for reimbursement to any third-party payor or the patient for the Product the patient receives at no charge through the Program. I also agree to inform NS Pharma, Inc. of any Serious Adverse Events, whether the event is related to the Product or not. By including my email address above, I agree to receive communication related to the NS Support Patient Assistance Program by email.

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION (NO STAMPS ALLOWED): I certify that treatment with VILTEPSO is medically necessary for this patient. I have reviewed the current VILTEPSO Prescribing Information and I will be supervising the patient's treatment. I authorize NS Support to act on my behalf to transmit this prescription to ARx Patient Solutions Pharmacy.

PRESCRIBER NAME (Please Print) _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

(Prescriber's signature required. Stamped signature not allowed.)

Questions? Call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8 AM–8 PM ET.

Patient Assistance Program Eligibility Requirements & Terms and Conditions

- You must be a citizen or a permanent resident of the US or its territories and reside in the US or its territories.
- You must not be covered, in whole or in part, by government health insurance (eg, Medicare, Medicaid, CHIP, TRICARE, Indian Health Service, Department of Defense, or other federal or state assistance programs).
- You are being treated as an outpatient by a licensed healthcare professional in the US and have been prescribed VILTEPSO® (viltolarsen) by a licensed healthcare professional.
- You must be uninsured.
- Your income must not exceed 4 times the Federal Poverty Level based on household size (Federal Poverty Level Guidelines available at <https://aspe.hhs.gov/poverty-guidelines>).
- You may be required to submit accurate and complete documentation (eg, most recent federal tax return, W-2, pay stubs, Social Security Award Letter or check) as requested by NS Pharma, Inc. each year to validate levels of income.
- You and your prescriber may not bill, charge, seek credit for or otherwise submit any claim for reimbursement for VILTEPSO provided through the Patient Assistance Program to any third-party payor.
- NS Pharma, Inc. and NS Support have the right to verify your eligibility, including the right to audit any information provided on the Patient Start Form, and the right to contact you to confirm receipt of medications.
- NS Pharma, Inc. and NS Support in their sole discretion can determine your eligibility to participate in the NS Support Patient Assistance Program.
- Approved patients will be eligible to receive assistance for one year from the date of enrollment for each enrollment form submitted.
- The Patient Assistance Program covers only the cost of VILTEPSO and not the cost of any infusion services or healthcare provider visits, which are the sole responsibility of the patient.
- The program requires that you (or your parent, guardian, or legal representative) re-enroll every year by completing an NS Support Patient Assistance Program Form for VILTEPSO and provide proof of income.
- A notice regarding re-enrollment will be sent to you (or your parent, guardian, or legal representative) 45 days in advance of the expiration of your participation in the program.
- Patients (or their parent, guardian, or legal representative) must notify NS Support of any changes in their total gross income and/or health insurance status.
- Patients who no longer satisfy the eligibility requirements will be immediately withdrawn from the NS Support Patient Assistance Program, including patients participating in the NS Support Patient Assistance Program who become eligible for Medicaid coverage.
- NS Pharma, Inc. has the right to modify, alter, or cancel the NS Support Patient Assistance Program at any time without prior notification.

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For more information about VILTEPSO, visit www.VILTEPSO.com and see full [Prescribing Information](#).