PRIALT® (ziconotide) intrathecal infusion

ESTEVE TOGETHER
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ESTEVE Together for PRIALT Patient Assistance Program Enrollment (PAP) Form

Phone: 1-833-Esteve-1 (833-378-3831)
Fax: 1-855-774-2583

FINANCIAL ASSISTANCE: Please complete pages 1 and 2
PATIENT SIGNATURE REQUIRED ON ALL SUBMISSIONS.

1. PATIENT INFORMATION

Patient Name: _____

Sex: ☐ Male ☐ Female Date of birth (MM/DD/YYYY): _____

Address: _____

City/State/ZIP: _____

Home phone: _____ Cell phone: _____

Preferred phone: ☐ Home ☐ Cell

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION

Please submit copies of both sides of patient's insurance card(s).
Check if patient does not have insurance. ☐

Primary insurance: _____

Policy ID #: _____ Group #: _____ Phone #: _____

Policy holder name (if not patient): _____

Employer: _____

Secondary insurance (if applicable): _____

Policy ID #: _____ Group #: _____ Phone #: _____

3. PRESCRIBER INFORMATION

Prescriber name: _____

Address: _____

Practice name: _____

City/State/ZIP: _____

NPI #: _____ State Med Lic #: _____

Office contact name: _____

Direct phone/ext: _____

Fax: _____

Specialty: _____

Tax ID #: _____ PTAN: _____

Setting of care: ☐ Physician's office ☐ Hospital outpatient ☐ Home infusion ☐ ASC ☐ Other (explain): _____

4. DIAGNOSIS, CLINICAL, AND TREATMENT INFORMATION

Diagnosis: _____ ICD-10 code: _____

Has this patient been diagnosed with severe chronic pain for which intrathecal (IT) therapy is warranted?: ☐ Yes ☐ No

Currently taking PRIALT? ☐ Yes ☐ No If yes, start date: _____

Existing IT pump? ☐ Yes ☐ No If no, provide implantation date: _____

5. REQUIRED: HEALTHCARE PROFESSIONAL POLICY AND CONSENT

Esteve Pharmaceuticals LLC and its contractors and agents (together "Esteve"), will use the information you provide to administer and improve ESTEVE Together (the "Program") in accordance with its privacy notice. You may request a copy of the privacy policy by emailing customercare@esteve.com. By signing below, you represent, covenant, and certify as follows: (i) My patient has provided all required written authorization(s) as required by all applicable federal or state laws to release to Esteve and the Program all patient information needed for this application, including without limitation financial and personally identifiable information in order to (1) conduct coverage support services, and (2) determine eligibility and enroll patient for financial assistance; (ii) All of the information provided in this application is complete and accurate; (iii) PRIALT® (ziconotide) was prescribed based on my medical judgment or the medical judgment of another healthcare professional in my office; (iv) I understand and have explained to my patient that Esteve may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any particular part of the Program; (v) I understand and agree that any medications supplied by Esteve under the Program are for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, submitted to any third party payor (private or government) for reimbursement, or counted toward the patient's Medicare Part D out-of-pocket costs; (vi) I have not received nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Program; (vi) I understand that I am under no obligation to prescribe any Esteve drug and I have not received and will not receive any benefit from Esteve for prescribing a Esteve drug: and (viii) if I become aware of any errors in the information provided, I will promptly notify Esteve of those errors.

I authorize Esteve and the Program to act as my representative, and on behalf of myself and my patient, to initiate any benefits investigation (BI), prior authorization (PA) and appeals support, co-pay card, and co-pay assistance foundation referrals. By signing below, I request that Esteve and the Program assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with the product noted in the Drug Therapy portion of this form. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed forms will be provided to my office by Esteve and the Program for possible completion and submission to the health plan. I request that Esteve and the Program actively monitor the status of the prior authorization submission. I request that Esteve and the Program provide status updates to my office with respect to this patient's prior authorization for treatment with the product noted in the Drug Therapy portion of this form.

Prescriber's Signature (NO STAMPS): _____ **Date:** _____

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1. PATIENT FINANCIAL INFORMATION

Annual Gross Household Income: $ _____ # of Household Members (including patient): _____

Please attach or complete the embedded prescription if you are seeking the PAP for your patient. Please note, eligibility for the PAP is based on the Federal Poverty Level and may change year to year. Income will be verified using tax returns or other alternate financial documentation. In cases where income cannot be verified, or there are discrepancies, additional proof of income may be required.

2. PRESCRIPTION INFORMATION

☐ **Rx for PRIALT® (ziconotide) intrathecal infusion Patient Assistance Program**

☐ **I authorize the dispensing pharmacy to dispense all doses as one prescription**

Quantity: 1 mL vial _____ 5 mL vial _____ 20 mL vial _____ **Refills:** _____ **Target Start Date:** _____

Other Directions: _____

With signature, I authorize Esteve Pharmaceuticals LLC and the specialty pharmacy to dispense PRIALT as part of the Patient Assistance Program.

Prescriber's Name (please print): _____

Prescriber's Signature (NO STAMPS): _____

Please attach a separate prescription if this section does not comply with your state's prescription law. ☐ **Rx for PRIALT is included or embedded with this fax**

3. PREFERRED SHIPPING LOCATION

☐ Prescriber's Office (as provided on page 1)

☐ Other Location (eg, infusion center)

Facility Name: _____

Recipient Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Setting of care: ☐ Physician's office ☐ Hospital outpatient ☐ Home infusion ☐ ASC ☐ Other (explain): _____

4. REQUIRED: PATIENT SIGNATURE FOR INCOME VERIFICATION

I give my doctor, Esteve Pharmaceuticals LLC (Esteve), and the Program administrator and their employees, agents, and contractors permission to use my personal information related to my medical condition, treatment, and management, as well as all information provided on this form, including contact and any prescription information ("Personal Health Information") to verify the information 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 once disclosed to Esteve, my Personal Health Information disclosed under this consent form may be further disclosed and used to determine 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 Esteve Privacy Policy. I understand that the Program can request more information from me at any time; and Esteve can change or stop the Program at any time for any reason. I understand that once my information has been disclosed, federal privacy laws, including HIPAA, may no longer restrict its use or disclosure. 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). I understand that I may revoke this authorization at any time by sending written notice of revocation to Esteve Pharmaceuticals LLC at 89 Headquarters Plaza #350, Morristown, NJ 07960, except to the extent that action already has been taken in reliance on this authorization. I understand that I have a right to receive a copy of this signed authorization.

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.

☐ **I attest that I am a US resident.**

Patient/Guardian Name (please print): _____

Patient/Guardian Signature: _____ **Date:** _____

Upon receipt of a completed application, the healthcare professional and the patient will be notified of program eligibility. If the patient is eligible for this program, the prescribed quantity of PRIALT will be shipped to the address indicated in Section 3 above.

ESTEVE

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