VALEANT® COVERAGE PLUS

Valeant® Coverage Plus Program (VCPP) Enrollment Form

ATTENTION: PATIENT INFORMATION SECTION MUST BE COMPLETED PRIOR TO THE HEALTHCARE PROVIDER FILLING OUT PROVIDER CERTIFICATION SECTION

The Valeant® Coverage Plus Program (VCPP) helps patients secure access to the following products, if and when your healthcare provider prescribes them: Syprine® (trientine hydrochloride) and Cuprimine® (penicillamine). VCPP offers the following services:

Reimbursement Counseling: At your request, VCPP will investigate insurance coverage availability for the product prescribed on the enrollment form. This service includes information regarding the prior-authorization process, if applicable, as well as the claim denial/appeal process.

Copay Assistance: Patients who have coverage for Syprine® (trientine hydrochloride) and Cuprimine® (penicillamine) through their insurance may be eligible* to receive the prescribed product for as little as $25. Patients, who have insurance, but whose plan does not cover the product, may also be considered for alternate assistance.

Patient Assistance: Subject to eligibility requirements, patients may be considered for the Patient Assistance Program (PAP) if they do not have insurance coverage.

Patients without insurance coverage may be provided product at no cost if they meet pre-established eligibility criteria. These include the following:

- Completed VCPP enrollment form (with patient and provider signatures)
  - Once the VCPP enrollment form is completed, signed, and returned to VCPP, the program can begin to provide product pending validation of patient qualification
  - Attach a valid prescription to the enrollment form
- Documentation of household income
  - Acceptable forms of income documentation include the patient's IRS 1040 form from the most recent tax year, W-2, or Social Security Benefit statement
- Proof of US residency
  - You must reside in the United States, Puerto Rico or the U.S. Virgin Islands

All services offered by VCPP, listed above, require a completed enrollment form containing both patient and prescribing healthcare provider signatures. Completed enrollment forms can be mailed or faxed to:

Valeant® Coverage Plus Program
PO Box 220667, Charlotte, NC 28222-0667
Fax: (855) 735-4624

If you have any questions about the program, or application process, please call **(888) 607-7267**. VCPP representatives are available Monday through Friday, 8:00 AM - 8:00 PM, Eastern Standard Time.

Please see Boxed Warning for Cuprimine below regarding the risk of toxicity, and accompanying full Prescribing Information.

WARNING

Physicians planning to use penicillamine should thoroughly familiarize themselves with its toxicity, special dosage considerations, and therapeutic benefits. Penicillamine should never be used casually. Each patient should remain constantly under the close supervision of the physician. Patients should be warned to report promptly any symptoms suggesting toxicity.

VALEANT Pharmaceuticals North America LLC

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VCPP Enrollment Form

Return this completed application with a valid prescription to:
Valeant® Coverage Plus Program, PO Box 220667, Charlotte, NC 28222-0667
Telephone: (888) 607-7267 Fax: (855) 735-4624

Check the product for which you are requesting assistance:

☐ Syprine® (trientine hydrochloride) Signature: _____

☐ Cuprimine® (penicillamine) Signature: _____

PATIENT INFORMATION

Patient Name: _____ SS#: _____ DOB _____

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

Day Phone: _____ Evening Phone: _____

☐ Yes, I authorize messages to be left on my voicemail regarding the information I've provided and the status of my prescription.

DELIVERY INFORMATION (Please indicate shipping address if different from above)

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

Delivery Contact Name: _____ Contact Phone: _____

INSURANCE INFORMATION (complete or include demographic sheet)

Primary Insurance (Include Medicare information, if applicable)

Insurance Company Name: _____ Policy ID #: _____ Group #: _____

Phone #: _____ Subscriber Name: _____ Date of Birth: _____

Prescription Card #: _____ Carrier: _____ Rx Card Phone#: _____

Secondary Insurance (Include Medicare information, if applicable)

Insurance Company Name: _____ Policy ID #: _____ Group #: _____

Phone #: _____ Subscriber Name: _____ Date of Birth: _____

Prescription Card #: _____ Carrier: _____ Rx Card Phone#: _____

FINANCIAL INFORMATION (Patient Assistance Only)

Current gross annual household income: $_____ Number of members in household: _____

Income Verification Source: ☐ 1040 ☐ W-2 ☐ Social Security Benefit Statement

I, _____ (patient's name) verify that the information provided in this application is complete and accurate. I do not have the financial resources to pay for product. I agree that if I am eligible and receive any free product, approval is not valid for prescriptions reimbursed under Medicaid, a Medicare drug benefit plan, or any other federal or state programs (such as medical assistance programs). Program approval is not valid for Massachusetts residents or where otherwise prohibited by law. The patient is responsible for reporting receipt of this offer to any health insurer, health plan, or third-party payer as may be required. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that Valeant reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

PATIENT AUTHORIZATION (Required)

I authorize my healthcare providers and health plans to disclose my protected health information ("PHI") to Valeant and its agents and contractors ("Valeant") to: (1) establish my eligibility for benefits through the Valeant® Coverage Plus Program (2) communicate with my healthcare providers and me about my medical care; and (3) provide support services including facilitating the provision of product to me. I understand that once my PHI has been disclosed to Valeant, federal privacy laws may no longer restrict its further disclosure. Valeant agrees to use and disclose this information only for the above purposes and as permitted by law.

I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Valeant in writing and submitting the cancellation by fax or by mail to: (855) 735-4624 or PO Box 220667 Charlotte, NC 28222-0667. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient Signature: _____ **Date**: _____

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PROVIDER INFORMATION

Provider Name: _____ NPI#: _____ DEA #: _____

Tax ID# / Provider ID #: _____ State License #: _____

Site/Facility Name:_____

Street Address:_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Name: _____

CLINICAL INFORMATION (Please Attach Valid Prescription to Form)

Diagnosis Code(s): _____

PROVIDER CERTIFICATION (Required)

I attest that the information provided is current, and accurate to the best of my knowledge. I certify that product is medically necessary for this patient and I will be supervising the patient's treatments. I have obtained from my patient all required authorizations for the release to Valeant and its agents and representatives of my patient's identification and insurance information. I understand that any information provided is for the sole use of Valeant and its agents and representatives to verify my patient's insurance coverage and to assess, if applicable, patient's eligibility for participation in the Valeant® Coverage Plus Program ("VCPP") and to otherwise administer VCPP. I understand that application to the VCPP does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the patient assistance program ("PAP"), and I agree to immediately notify VCPP if I become aware of such a change in status. I certify that I will not bill for or accept payment from patients (or any third party), in whole or in part, for product obtained through the PAP. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for product supplied through the PAP, I will immediately notify a VCPP representative, and I understand that in such event Valeant will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe product and that I have not received nor will I receive any benefit from Valeant or its agents or representatives for prescribing product.

Check box to confirm your agreement to receiving faxes from the Valeant® Coverage Plus Program ☐

Provider Signature: _____ **Date:** _____

Supervising Physician: _____ **Date:** _____

No Stamps. Physician signature required

NY Prescriptions must be submitted on NY State Rx form

*Patients ineligible for the co-pay savings offer include those enrolled in Medicare, Medicaid, VA/DOD (Tricare), the Indian Health Service, or any other federally or state-funded healthcare program, or where prohibited by law, or whose commercial healthcare insurance providers prohibit the use of select specialty pharmacies. These patients may qualify for alternative financial assistance. For more information, call a Valeant Coverage Plus representative at 888-607-7267.

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