PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

Thank you for your interest in the Impax Specialty Pharma Patient Assistance Program. This program is for the ZOMIG® (zolmitriptan) family of products, ALBENZA® (albendazole), RYTARY® (carbidopa and levodopa) extended-release capsules and EMVERM™ (mebendazole) chewable tablets. Attached is a copy of the application form.

To be eligible to receive free medicine from Impax Specialty Pharma, patients must be U.S. residents, not have affordable coverage for the prescription, have total household income that meets the program eligibility requirements and, if enrolled in a Medicare Part D plan, have spent at least 3% of annual household income out-of-pocket on prescription medicines.

APPLICATION INSTRUCTIONS FOR PATIENTS – REQUIRED

- Fully complete all 3 of below sections:
  - § Patient Information (Section 1)
  - § Insurance Information (Section 2)
  - § Income Information (Section 3)
- Sign the application
- Attach a copy of last year's tax return or other records for proof of income. Some examples are IRS Forms 1040, 1040A, 1040EZ, W2, 1099PR, and 1099 Social Security Statement. If you did not file a tax return, please attach an IRS Form 4506-T, which shows that you did not file.
- **If you have a Medicare Part D plan**, attach proof of what your household has spent on prescription drugs this year. You will need to provide one of the following: Explanation of Benefits Statement from your Medicare Part D plan provider or a pharmacy printout of year-to-date prescription history.

APPLICATION INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

- Complete Practitioner Information Section 4. Provide phone, fax, and DEA or State License number.
- Have patient fully complete the Patient Information Sections 2, 3, and 4 and sign the application.
- Attach original valid prescription(s) with physician signature.
- Fax or mail the application, financial documentation, proof of prescription spend (if applicable) and prescription to:

Impax Specialty Pharma Patient Assistance Program
PO Box 66554
St. Louis, MO 63166-6554
Phone 1-877-764-9021 Fax 1-877-764-9022

If approved, patients are eligible to receive free medication for up to one year. Medications will be sent to the patient's home. Impax will send an application for renewal when a patient's enrollment is due to expire.

For questions regarding this program or application, please call us at **1-877-764-9021**, Monday through Friday, 8:00 am to 5:00 pm CST.

The following medications are available through the Impax Patient assistance program.

***If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form.**

ZOMIG® 2.5 mg Tablets
ZOMIG® 5 mg Tablets
ZOMIG® ZMT 2.5 mg
ZOMIG® ZMT 5 mg
ZOMIG® 2.5 mg Nasal Spray
ZOMIG® 5 mg Nasal Spray

RYTARY® in the following strengths (available in a 30, 60 or 90 day supply)
RYTARY® 23.75 mg / 95 mg
RYTARY® 36.25 mg / 145 mg
RYTARY® 48.75 mg / 195 mg
RYTARY® 61.25 mg / 245 mg

ALBENZA® 200mg Tablets- 2 count package (available up to a 28 day supply)

EMVERM™ 100mg Chewable Tablets-1 count package
(Providers please include a separate prescription for every member of the applicant's household being treated with Emverm™)

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SECTION 1 - PATIENT INFORMATION: (Please print clearly) Note: Upon approval, medication will be sent to the patient's address		
Last Name, First Name:	Social Security or ID Number:	Patient Date of Birth: / /
Street Address/Shipping Address:	Phone Number: ( )	U.S. Resident: o Yes o No
City: State: Zip Code:	Marital Status: o Married o Single o Divorced o Widow/Widower	Gender: o Male o Female
List any other Patient Medications:	U.S. Veteran: o Yes o No	Disabled: (Approved by Social Security) o Yes o No
List any Patient Drug Allergies:	Number of people in household (include self): (circle one) 1 2 3 4 5 6 7	

Household member also receiving treatment with the Emverm™ Product:

1st Member:
First Name ______________________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

2nd Member: First Name ___________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

3rd Member: First Name ___________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

4th Member: First Name ___________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

5th Member: First Name ___________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

6th Member: First Name ___________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

7th Member: First Name ___________________ Last Name:____________________
DOB:_____________ Drug Allergies:____________
Prescription included: ☐ Yes ☐NO

SECTION 2 - PATIENT INSURANCE INFORMATION	
Do you have Medicaid? o Yes o No	Do you have a State Patient Assistance Program? o Yes o No
Do you have Medicare A? o Yes o No	Do you have Medicare B? o Yes o No
Do you have Medicare D? o Yes o No *(If yes, Please attach current years proof of Out-of-Pocket Prescription costs)*	

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Do you have prescription drug coverage?

o Yes o No

(If yes, please attach a copy of your insurance card front and back.)

SECTION 3 - PATIENT INCOME INFORMATION
Note: Attach Proof of Income (Examples: Federal Tax Return, IRS Form 1040, 1040EZ, 1099, Social Security or Disability Statement)

TOTAL GROSS MONTHLY INCOME: $	TOTAL ASSETS*: $ **Only include money in checking or savings accounts, certificates of deposit, stocks and bonds, IRA's, annuities and any other cash holdings. DO NOT include the dollar value of any real estate or personal belongings.*

If you have recently faced a financial challenge please check the appropriate box below and provide supporting documents with your application.

o Change in household income (letter from employer or former employer)   o Change in marital status (legal record supporting change)

o Change in household number (copy of birth or death certificate)

Informed Consent and Authorization for Use and Disclosure of Health Information for Patient Assistance Program

I understand that completing this form does not ensure that I will qualify for the Impax Specialty Pharma Patient Assistance Program ("Program"). I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Program if I obtain coverage through another source or if I no longer meet the income criteria for the Program. I authorize my healthcare provider to disclose medical information and related information to Impax Inc., ("Company"), including Express Scripts Specialty Distribution Services, Inc. any of its subsidiaries or affiliates (the "Program Administrator"), and I authorize Company to obtain and disclose information as deemed necessary to verify the accuracy and completeness of this application and to provide services available through the Program. I also authorize Company to release medical information and related information to the Centers for Medicare and Medicaid Services ("CMS") for purposes of administering the Program. I understand that personal identifying information provided on this form will be available to Company and its agents for the purpose of administering the Program. I understand that Company reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program. If I decide to terminate my authorization for my health care providers and my insurers to disclose my information to Company, I shall notify Company in writing at Impax Specialty Pharma Patient Assistance Program, PO BOX 66554 St. Louis, MO 63166-6554 that I no longer provide such authorization which termination shall be effective upon Company's receipt of such notification. I understand that I have a right to obtain a copy of the information my health care providers or insurers have provided to Company upon request to Company. I understand that I may decline to sign this form and decline being considered for the Program. I understand that signing this form does not affect the way my health care providers or insurer will provide me with their respective services. I understand this authorization is valid for the duration of my enrollment period and the information used or disclosed may be subject to re-disclosure and no longer protected by HIPAA.

Original Signature of Patient or Power of Attorney (*Required to process application*) **If signing as POA, please send legal document.** X	**Date:**

SECTION 4 - PRACTITIONER INFORMATION: (Please print clearly)
Please remember to send a separate prescription for the medication being requested.

I authorize Impax Inc. to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan; provided that if this prescription is not so designated. Impax Inc. is authorized to transmit this prescription to a network pharmacy it selects, or to the pharmacy otherwise indicated.

Original Signature of Prescribing Healthcare Provider Required *(Must match signature on prescription)*
X

Last Name, First Name:			Office Contact Person:
Office Street Address:			
City:	State:	Zip Code:	Phone Number: ( )

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	Fax Number: ( )
State License # (or DEA#, if required):	

MAIL/FAX ALL DOCUMENTS TO:
Impax Specialty Pharma Patient Assistance Program
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Phone 1-877-764-9021 Fax 1-877-764-9022

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