Lupin Pharmaceuticals **Patient Assistance Program**

Administered by:
Truax Patient Services
1112 Railroad St, Suite #4
Bemidji, MN 56601
Phone: (877) 438-9759
Fax: (877) 438-9759

We appreciate your interest in receiving Solosec™ (secnidazole) at no cost through the Lupin Pharmaceuticals Patient Assistance Program. Lupin Pharmaceuticals cares, which is why we've made this assistance program available to those who may not be able to afford treatment.

Will I qualify for the Lupin Pharmaceuticals Patient Assistance Program?

If you can answer "yes" to the following questions, begin the enrollment process by completing and signing the Patient Information Section on the following page. You may fill out this form electronically or print it out and fill it out by hand. Be sure to provide all requested information, since incomplete applications will not be processed until any missing information is received.

ARE YOU...

- A citizen or permanent resident of the United States, with a valid Social Security Number?
- Under the care of a licensed healthcare provider who is authorized to prescribe, dispense, and administer medicine in the United States?

DO YOU...

- Lack insurance coverage for Solosec?
- Meet the income eligibility criteria to the right?

CAN YOU...

- Provide a list of all other medications you're currently on?
- Provide adequate documentation supporting your ANNUAL household income? Acceptable forms of documentation include:
  - Copy of most recently filed income tax return (IRS Form 1040) or W-2, **-or-**
  - Copy of transcript received through submission of IRS 4506-T, **-or-**
  - Copy of most recent Social Security/Disability monthly check, award letter, benefit statement of 1099, **-or-**
  - Copy of unemployment determination letter, **-or-**
  - Certified letter stating you have no income in your total household.

Total household income (adjusted gross/taxable income) must not exceed the income criteria below (amount may change annually).

# of People in Household*	Annual Income
1	$18,210
2	$24,690
3	$31,170
4	$37,170
5	$44,130

For each additional person, add $6,131

**Income thresholds are 150% of the Federal Poverty Guidelines. If you have more than 5 people in your household or live in Alaska or Hawaii, visit https://aspe.hhs.gov/poverty-guidelines for more information.*

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Instructions for Healthcare Providers

- Complete and sign the Healthcare Provider Information section. We will accept the signed Healthcare Provider Information as a legal prescription.
- Provide Doctor NPI Number
- Complete the REQUESTED MEDICATION section

How to Submit the Application and Next Steps

You have two options for submitting your complete application and supporting documents:

- Email all materials to **solosec@truaxpatientservices.com**
- Fax all materials to **(877) 438-9759**

Medication will be mailed to the listed patient address through Truax Patient Services Pharmacy unless an alternative address is specified for health reasons. You will be notified of the application's status upon completion of our review and evaluation. Please note, program rules are subject to change without notice. If you have questions or need further assistance, please call (218) 766-7290 or (218) 766-6593 between 9:00AM and 5:00PM Central Standard Time, Monday through Friday.

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Patient Enrollment Form

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Please provide all of the requested information below, sign, and date. Applications to receive Solosec™ (secnidazole) at no cost through the Lupin Pharmaceuticals Patient Assistance Program will not be considered for enrollment until all application components are received.

Patient Information

First Name: ____________________________ MI: ______ Last Name: _________________________ Date of Birth: ____/ ____/ ____

Mailing Address: ____ City: _______________________ State: ______ Zip: ____________

Social Security Number: ______ - ______ - ______ Phone Number: ______ - ______ - ______

Full name of contact person if different from above: _____________________________________ Phone Number: ______ - ______ - ______

Known drug allergies: ____

Medications currently taking: ____

Patient Eligibility Information – Attach Proof of Annual Household Income (Required)

TOTAL ANNUAL HOUSEHOLD INCOME: $ __________________
(include all annual income, wages, Social Security, pension, disability, interest earned on savings, etc.)

Household size (number of persons living in the home): ________

Do you lack insurance coverage for Solosec? ◯ Yes ◯ No

Do you have any public or private prescription drug coverage or are you in any benefit program that helps pay for your prescription drugs?
◯ Yes ◯ No

I attest that the above information is complete and accurate. I attest that I have insufficient financial resources to pay for the prescribed therapy. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payer (private or government) for the medication. By my signature, I authorize the release of the information about me and my medical condition to the LUPIN PHARMACEUTICALS, Inc. Patient Assistance Program (LPAP) and/or their agents. I authorize TRUAX PATIENT SERVICES and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into (LPAP) and administration of (LPAP), which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities (LPAP) may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. My signature certifies that the medication received from (LPAP) will not be resold nor offered for sale, trade or barter and will not be returned for credit. Additionally, I agree that at any time during my enrollment, the (LPAP) may request additional documentation to authenticate the statements made on my application. The (LPAP) and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient Signature: ____ Date: ________________________

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Healthcare Provider Form

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This form is for the prescribing practitioner to complete. Please fill out the following information and submit via email or fax. Applications will not be considered until they are received in their entirety.

Healthcare Provider Information

First Name: ________________________ Last Name: ________________________

Check which of the following applies to you: ○ MD ○ DO ○ NP ○ PA

Facility Name: ________________________ NPI#: ________________________

Street Address: ____________________ City: ______________ State: ______ Zip: __________

Phone Number: ______ - ______ - ______ Fax Number: ______ - ______ - ______

○ Check the circle to the left to confirm that you are requesting that a single course of **Solosec™ (secnidazole) 2 g oral granules** be sent your patient if they are approved for the Lupin Pharmaceuticals Patient Assistance Program.

This signed application will be taken as a legal prescription.

I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the LUPIN PHARMACEUTICALS, Inc. Patient Assistance Program (LPAP) and /or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage, including Medicaid, Medicare or other public or private programs. I understand that (LPAP) reserves the right to modify or terminate this program at any time. I understand that (LPAP) reserves the right to recall or discontinue product at any time without notice.

Healthcare Provider Signature: ______________________________ Date: ______________

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Disclosure, Notice of Rights and Other Information

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION:

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

Persons/organizations authorized to use or disclose the information: My insurer, pharmacist, physician or other health care provider.

Persons/organizations authorized to receive the information: LUPIN PHARMACEUTICALS, Inc. Patient Assistance Program (LPAP) and authorized employees. Truax Patient Services and its authorized employees.

Purpose of requested use or disclosure: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.

This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.

EXPIRATION:

This Authorization expires one (1) year after I cease to participate in the Program.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling (877) 438-9759 and mailing a written revocation, signed by me or on my behalf, to Truax Patient Services 1112 Railroad St SE STE#4, Bemidji, MN 56601. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclose in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization.

Patient Signature: ____ Date: ____________________

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