RadiusAssist
Patient Assistance Program

PROGRAM APPLICATION

Prescribers and Patients must review and include the required documentation, as well as complete and sign this form.

Fax or mail all pages of the application as well as all required documentation to:

Radius Assist Patient Assistance Program
PO Box 5536
Louisville, KY 40255
Fax: 1-800-910-4610 | Phone: 1-866-896-5674

PATIENT ELIGIBILITY CRITERIA:

Medicare Beneficiary	Commercially-Insured but Not Covered	Uninsured
• Patient must have an FDA-approved, on-label diagnosis for TYMLOS™ (abaloparatide) injection • Patient must have an Annual Household Income <300% Federal Poverty Level (FPL)* • Patient must be a US citizen or legal resident • Patient must not be enrolled in Medicaid, Tricare, or Veterans Administration benefit programs • Patient must have applied for and been denied the Low-Income Subsidy ("LIS")† from the Social Security Administration • Patient must not be eligible for State Pharmacy Assistance Programs in which TYMLOS participates	• Patient must have an FDA-approved, on-label diagnosis for TYMLOS • Patient must have an Annual Household Income <300% Federal Poverty Level (FPL)* • Patient must be a US citizen or legal resident • Patient must not be enrolled in Medicaid, Tricare, or Veterans Administration benefit programs • Patient must have neither insurance coverage for nor access to other coverage for TYMLOS	• Patient must have an FDA-approved, on-label diagnosis for TYMLOS • Patient must have an Annual Household Income <300% Federal Poverty Level (FPL)* • Patient must be a US citizen or legal resident • Patient must not be enrolled in a Medicare or commercial prescription drug plan or Medicaid, Tricare, or Veterans Administration benefit programs

* Find current U.S. Federal Poverty Guidelines online at www.aspe.hhs.gov/poverty-guidelines
† To apply for LIS, please contact the Social Security administration at (800) 772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/

INSTRUCTIONS:

1. Complete ALL fields to avoid return of incomplete application.
2. Make sure the application is signed and dated by the prescriber.
3. Make sure the patient signs the certification section.
4. Include all documents required per the **"Required Documentation"** section below. Please **DO NOT INCLUDE** patient medical records with this application.
5. Fax completed application and required documentation to **1-800-910-4610** or mail them to:
   Radius Assist Patient Assistance Program, PO Box 5536, Louisville, KY 40255.

REQUIRED DOCUMENTATION:

Prescribers	Patients
1. Prescriber Information (below) 2. Valid prescription (below) 3. Signed certification (below)	1. Most recent W2 or 1099 form. If you have no income, pay stubs and bank statements may be submitted. Self-Employed patients must attach a copy of the most current Federal Income Tax with appropriate schedules (C and/or F) 2. Photocopy of the front and back of the applicant's insurance card(s) 3. Photocopy of applicant's LIS denial letter (Medicare Part D enrollees only). The date on the LIS denial letter is valid for 12 months or until 12/31 of the year in which it was issued, whichever is sooner 4. A signed and notarized Power of Attorney (POA) for signatures other than the applicant's original signature 5. Signed certification (below)

ADDITIONAL INFORMATION:

- Although processing typically occurs faster, please allow up to 4 weeks for application processing and delivery of medication to the patient.
- Incomplete applications may be returned to the applicant or licensed prescriber with instructions for completion.
- If the applicant is approved, the licensed prescriber and applicant will be notified by mail. Approved applicants may receive up to a 3-month supply of medication at a time, for up to 12 months, subject to continued eligibility and pursuant to a valid prescription.
- If the applicant is denied, the licensed prescriber and applicant will be notified by mail.

PRESCRIBER INFORMATION

Prescriber Name (Last:) (First:)

Practice Name:

Practice Street Address: City: State: Zip:

Phone: Fax: State License Number:

NPI Number:

Office Contact Name (Last, First): Office Contact Email:

PRESCRIPTION AND PRESCRIBER CERTIFICATION

Product Name: TYMLOS™ (abaloparatide) injection 80 mcg **Directions**: Daily, subcutaneous 80 mcg injection

Dispense Quantity: ○ 30 days ○ 90 days Refills (select one): ○ 0 ○ 1 ○ 2 ○ 3

Ancillary Supplies: ○ One hundred (100) day needle supply Refills (select one): ○ 0 ○ 1 ○ 2 ○ 3 ○ Sharps container

Patient's cumulative lifetime use of TYMLOS™ and parathyroid hormone analogs (e.g. teriparatide) (in months)

PATIENT ICD-10/DIAGNOSIS CODE

○ M80. (Postmenopausal osteoporosis with current pathological fracture) ○ M81. (Postmenopausal osteoporosis without current pathological fracture)

By signing this form, **I certify the following**: (1) I am prescribing TYMLOS™ (abaloparatide) for the patient identified on this form based on my independent clinical judgment, and that this prescription medication is medically indicated for the patient and that it will be used as directed; (2) I have authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (3) my license is active and in good standing with my state medical board and I am not debarred by any local, state, or federal entities; (4) to the best of my knowledge, the patient identified on this form does not have prescription drug insurance coverage under (a) Medicaid, Tricare, or Veterans Administration benefit programs, (b) if a Medicare beneficiary, has applied for and has been denied LIS from the Social Security Administration and is not eligible for a state pharmacy assistance program in which TYMLOS participates, and (c) if commercially insured, has neither insurance coverage for nor access to other coverage for TYMLOS™ (abaloparatide); (5) I will immediately notify the Radius Assist Patient Assistance Program ("Radius Assist" or the "PAP") if I become aware that this patient's insurance or income status has changed; (6) I will be supervising the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge; (7) I will not submit an insurance claim or any other claim for payment for any medication dispensed or administered to the patient through the PAP from insurer, health plan, or government program, including Medicare and Medicaid. I understand that: (1) Radius Assist reserves the right to verify all information provided by any healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment in the PAP based on available resources; (2) Radius Assist reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) Radius Assist, and its agents and assignees, are relying on the certifications in this form.

Original Prescriber Signature: **Date:**

PATIENT INFORMATION

Patient Name (Last:) (First:)

Street Address: City: State: Zip:

Date of Birth: / / Social Security Number: ○ Female ○ Male ○ Prefer not to answer

Primary Phone: Best Time to Call: ○ AM ○ PM

Email Address: Are you a permanent, legal resident of the United States? ○ Yes ○ No

INCOME INFORMATION

Current Annual Household Income OR Monthly Income: Number of persons in household (Include yourself, spouse and dependents):

INSURANCE INFORMATION

Patient Is Uninsured: ○ Yes ○ No Copy of Insurance Card (Front and Back) Attached: ○ Yes ○ No

Name of Primary Insurer: Insurer Telephone:

Policy Number: Group Number: Policyholder Name:

Policyholder Date of Birth: / / Policyholder Relationship to Patient:

Name of Pharmacy Benefit Manager (PBM):

PBM Member ID Number: PCN: BIN: PBM Group Number:

Policyholder Name: Policyholder Date of Birth: / / Policyholder Relationship to Patient:

OTHER COVERAGE INFORMATION:

Are you enrolled in Medicaid? ○ Yes ○ No State Pharmacy Assistance Program? ○ Yes ○ No

Are you enrolled in Medicare? ○ Yes ○ No Medicare ID #:

Are you enrolled in a Medicare D Plan? ○ Yes ○ No Are you receiving a Low-Income Subsidy (otherwise known as Extra Help)? ○ Yes ○ No

Are you enrolled in any other government payer programs such as Tricare, Veterans Administration, etc.? ○ Yes ○ No

PATIENT CERTIFICATION AND AUTHORIZATION

PATIENT DECLARATION:

I CERTIFY: (1) I do not have the ability to pay for the medication(s) requested by my healthcare provider on the attached prescription(s). (2) I will notify Radius Assist within thirty (30) days if my financial status or health insurance coverage changes. (3) I will not sell, trade, or distribute any products given to me via Radius Assist. (4) I will verify my PAP application status and receipt of the indicated medication(s) upon request by Radius Assist. (5) If I receive free product through Radius Assist, I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program, including Medicare and Medicaid. (6) If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my True Out-of-Pocket (TrOOP) cost for prescription drugs. (7) All of the information provided in this application, including household income and insurance, is complete and accurate.

I UNDERSTAND AND AGREE: (1) That program assistance will terminate if the PAP becomes aware of any fraud or if this medication is no longer prescribed for me. (2) That completing this application does not ensure that I will qualify for patient assistance, and that my eligibility to participate in Radius Assist is subject to the decision of Radius. (3) That I may be required to provide proof of ineligibility for certain other prescription coverage programs in order to meet the eligibility requirements for the PAP. (4) That Radius Assist reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. (5) That I may choose to opt out of Radius Assist at any time by notifying a representative at 1-866-896-5674 or by notifying the program in writing at the address listedabove. (6) I authorize Radius Assist and its administrator to forward this prescription to a dispensing pharmacy on my behalf.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION: I authorize my healthcare providers, my health plan, and insurers to give health and other information about my use or need for medications provided under Radius Assist to third-party Radius vendors in charge of administering the PAP. My health and other information are referred to below as "Information."

I authorize Radius Assist, Radius, their agents, and third-party contractors or their service providers to further use and disclose my Information in connection with the PAP. I understand: (1) That my Information will include my name, address, Social Security number, income, prescription coverage, prescription for medication(s), financial documents, insurance records, and any other information provided on this form. (2) That people with the PAP, Radius, or others working on behalf of the PAP may see and use my Information for administering the PAP. (3) That my Information may be used to see if I meet the eligibility requirements to participate in the PAP, to obtain a credit report to help estimate my income as part of the eligibility determination process, to help me enroll in the PAP (if I am eligible), to find out whether I may be eligible for, or am already enrolled in, another program (including an insurance plan or other charitable program), to ship appropriate medication(s), and to contact me to seek feedback on Radius Assist services. (4) That I will be notified by the PAP if I do not meet the requirements to participate in the PAP.

WITHOUT LIMITING THE PURPOSES FOR THE DISCLOSURE OF INFORMATION SET FORTH ABOVE, I UNDERSTAND: (1) That the PAP, Radius, their agents, and third party contractors or service providers will keep my Information private, but that federal privacy laws may no longer protect my Information once it is disclosed, and that my information may be legally re-disclosed by recipients if not prohibited by state law. (2) That this authorization will expire 1 year from the date this form is signed unless I cancel it in writing. (3) That I may cancel this authorization at any time by giving written notice to Radius at the address on this form, but my cancellation will not change any actions taken with my Information prior to cancelling, and my enrollment in the PAP will end. (4) That I have the right to receive a copy of this authorization from my healthcare provider and/or Radius, and that I may inspect/obtain a copy of the information disclosed pursuant to this authorization. (5) That I can refuse to sign this form, and that if I refuse to sign, it will not change the way that my healthcare providers, health plans, and insurers treat me. (6) That if I do not sign this form, I will not be able to participate in the PAP.

Patient's or Patient Representative's Signature:

Date: