Lundbeck Migraine Patient Assistance Program Application

Instructions and Description of Service

PATIENT ASSISTANCE PROGRAM (PAP)

Lundbeck is committed to developing and providing innovative therapies that help improve patients' lives. We realize the challenges of the disorders we treat remain substantial, and we are dedicated to supporting the people behind the disease, as well as their families, their caregivers, and their communities. Our engagement with patient communities is at the core of who we are.

As part of our commitment, we work to provide appropriate assistance to patients who seek access to our therapies. The Lundbeck Migraine Patient Assistance Program (PAP) may be available to patients who have limited financial resources and who do not have insurance coverage for their medication. Eligibility criteria apply.

INSTRUCTIONS

Complete all sections of the Patient Application.	**Ensure all applicable signature fields are complete.**	**Fax the completed Patient Application and all required financial documentation to the Lundbeck Migraine Patient Assistance Program at 1-866-889-0580.**

Patient Confidentiality

Patient confidentiality is of primary importance to us. All patient information will remain confidential.

Important Reminder

Please be certain that all applicable pages of the Patient Enrollment Form & Prescription are completed and include all appropriate documentation when submitting this form. Incomplete forms slow the review process and, in some cases, may require the healthcare provider to reapply for the program(s).

Lundbeck Migraine Patient Assistance Program Application

1 Patient Information

Name (First, Last, Suffix) _____

Date of Birth _____ Gender ☐ Male ☐ Female

Home Address _____

City _____ State _____ Zip _____

Authorized Representative _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Email Address _____

2 Patient Insurance Information

Does the patient have health insurance? ☐ Yes ☐ No

Insurance Type: ☐ Commercial ☐ Government ☐ Other

Primary Medical Insurance Provider _____

Beneficiary/Cardholder Name _____

ID# _____ Group# _____

PCN# _____ BIN# _____

Prescription Insurance Provider _____

Group# _____ BIN# _____

PCN# _____

Does patient participate in any of the following? Check all that apply:

- ☐ Medicare Part B
- ☐ Medicare Part D
- ☐ Medicare HMO or Medicare + Choice or Medicare Advantage
- ☐ Medicare Program for Reimbursed Self-Injectable Drugs
- ☐ Medicaid
- ☐ Veterans Administration
- ☐ Indian Healthcare
- ☐ Public Health Services
- ☐ Workman's Compensation
- ☐ TRICARE/CHAMPUS

Any other Federal healthcare program(s), please list:

_____

3 Patient Financial Information

Household Adjusted Gross Income from IRS form 1040, 1040 EZ, or 1040 NR _____

Household Size based on IRS form 1040, 1040 EZ, or 1040 NR _____

Please attach a copy of the most recent year's federal tax return (IRS Form 1040, 1040 EZ, or 1040 NR) as well as the W2 form(s) that document your household income, or other verifiable financial statements and information. Please note that household income also includes alimony, child support, Social Security, pension or retirement payments, unemployment benefits, workers' compensation, and/or disability payments you receive.

The Lundbeck Migraine Patient Assistance Program application cannot be processed without this documentation.

Lundbeck Migraine Patient Assistance Program
Address: 2240 Taylorsville Road, Suite 1 PO BOX 5550 Louisville, KY 40255| Phone number: 1-877-288-9125| Fax: 1-866-889-0580

Lundbeck Migraine Patient Assistance Program Application

Patient Privacy Authorization *(Signature Required)*

I understand that, before I may receive assistance from the Lundbeck Migraine Patient Assistance Program ("PAP"), sponsored by Lundbeck LLC ("Lundbeck"), the administrators of the PAP, including their contractors or other representatives, will need to obtain, review, use, and disclose my personal health information ("PHI"), including information relating to my medical condition and prescription medications and the information included in this patient enrollment form. I therefore authorize each of my physicians, pharmacies, and health plans to disclose my PHI, as necessary, to (i) the administrators of the PAP and their contractors or representatives, in order to verify my eligibility to enroll in the PAP and to enroll me in the PAP if I am eligible; and (ii) the administrators of the PAP and their contractors or representatives, to investigate insurance coverage in connection with the PAP. I also authorize the administrators of the PAP, and their respective contractors or representatives to (i) use my PHI to provide the services described in this enrollment form, including to communicate with me by U.S. postal mail, telephone, text, or e-mail and to prepare summaries that do not include my PHI for statistical purposes; and (ii) share my PHI with one another and with my physicians and pharmacists as well as with Medicare, my health plans, and their administrators, contractors, or representatives, in order for them to coordinate my benefits and investigate my insurance coverage. I also authorize the administrators of the PAP and their contractors, representatives, and third-party services partners to disclose my PHI to authorized representatives of Lundbeck as necessary to ensure compliance with the rules of the PAP. I also authorize Lundbeck's authorized representatives to use my PHI to communicate with the administrators of the PAP, their contractors, representatives or third-party services partners, my physicians, pharmacies, and me for compliance purposes. If I have designated a Authorized Representative, I authorize the PAP, its administrators, and their third-party service partners to use my PHI to contact the person I have designated as my Authorized Representative for the purpose of verifying the information I have provided in this form and/or coordinating the provision of benefits that may be available to me under the PAP and to disclose my PHI, including information provided in this enrollment form, to my Authorized Representative for the purposes described in this paragraph. I understand that the PHI disclosed pursuant to this authorization, once disclosed, may not be governed by federal privacy law and may be subject to re-disclosure. I further understand that if I choose not to provide this authorization, it will not affect my eligibility for, or receipt of, treatment, including Lundbeck products, or health care insurance benefits, but that I will not be able to receive any assistance from the PAP. I understand that I may cancel this authorization at any time by telephoning the PAP at 877-288-9125 or by mailing a written request for cancellation to the PAP, 2240 Taylorsville Road, Suite 1 PO BOX 5550 Louisville, KY 40255. I understand that canceling my authorization will mean that my physicians, pharmacies, and health plans, as well as the PAP, its administrators, and contractors and representatives, may no longer rely on the authorization to use or disclose my PHI, but that any use or disclosure of such information that occurs before my cancellation is received will be unaffected by my cancellation.

I understand that if I do not cancel this authorization, the authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). The administrators of the PAP will retain the information I have submitted in accordance with Lundbeck's records retention policy. I understand that I am entitled to receive a copy of this authorization once it has been signed.

By signing, I certify that I have read and agree to the above Patient Authorization.

Patient Printed Name *(First, Last)* _____

Relationship to Patient ☐ **Patient** ☐ **Authorized Representative** ☐ **Caregiver**

Patient/Legal Guardian/Caregiver Signature X_____ **Date** _____

Lundbeck Migraine Patient Assistance Program Application

Patient Certification *(Signature Required)*

I certify that all of the information provided in this application, including information about household income, is complete and accurate. I understand that Lundbeck Migraine Patient Assistance Program ("PAP") assistance will terminate if the PAP becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have the prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that if I qualify for free medicine, it will be for the remainder of the current calendar year and should I require assistance in future years, I must reapply for PAP assistance. I understand that PAP reserves the right to modify the application form, modify or discontinue this PAP, or terminate assistance at any time and without notice. I authorize the PAP and its affiliates to forward the prescription to a dispensing pharmacy on my behalf. PAP is not responsible for verifying any information contained in the prescription forwarded as part of the enrollment process, including, without limitation, allergies, medical conditions, or other medications being taken by me. I understand that I will notify the PAP immediately if anything changes with my prescription, income or my insurance coverage. I understand that the PAP reserves the right to request documentation to verify the information provided in this application for purposes of determining my eligibility for assistance, and to conduct periodic audits of my enrollment, including the physician who will be supervising my treatment, to verify the information provided herein. I understand that I may opt out of receiving the PAP assistance by notifying the PAP at 877-288-9125. I understand that assistance received through the Lundbeck Migraine Patient Assistance Program is not insurance.

By signing, I certify that I am at least eighteen (18) years of age and that I have read and agree to the above Patient Certification and the terms and conditions of the Lundbeck Migraine Patient Assistance Program. By signing, I also certify that all information that I have provided in this application is complete and accurate.

Patient Printed Name *(First, Last)* _____

Relationship to Patient ☐ **Patient** ☐ **Authorized Representative** ☐ **Caregiver**

Patient/Legal Guardian/Caregiver Signature X_____ **Date** _____

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4 Clinical Information & Prescription

Prescribed Medication and Dose:

℞

Refills: **Quantity:** **Direction:**

Patient Name _____ **Patient Date of Birth** _____

Primary Diagnosis *(ICD 10 Code)* _____ **Secondary Diagnosis** *(ICD 10 Code)* _____

Current Medications _____

Allergies _____

Scheduled Infusion Date *(MM/DD/YYYY)* _____

5 Physician Information

Physician Name _____ **Physician NPI Number** _____

Facility Name _____

Address _____

City _____ **State** _____ **Zip** _____

Primary Phone _____ **Secondary Phone** _____

Fax _____ **Email Address** _____

6 Prescriber Declaration *(Signature Required)*

I certify that the patient and physician information contained in this Lundbeck Migraine Patient Assistance Program Application is complete and accurate to the best of my knowledge. I have prescribed _____ and certify that this prescription medication is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge. I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to the Lundbeck Migraine Patient Assistance Program for the purposes of verifying the patient's insurance coverage, seeking prior authorization if needed, on my patient's behalf, and providing information on appeals for denials of claims.

I authorize the forwarding of this prescription to a dispensing non-commercial pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free medicine received under the PAP and my team has informed the patient of this requirement.

By signing below (required), I have read and agree to Section 8. Prescriber Declaration.

(NOTE: Patient Assistance Program Application requests cannot be processed without signed Prescriber Declaration. Prescriber actual signature required; no signature stamp.)

Prescriber Printed Name *(First, Last)* _____

Prescriber Signature X _____ **Date** _____