SOLSTICE NEUROSCIENCES
A US WORLDMEDS COMPANY

Co-Pay Enrollment Application Form

Please complete the information listed below to apply for the Co-Pay Assistance Program for MYOBLOC. If you need assistance completing the application, please call **888-461-2255, Option 3**. **Completing this application does not guarantee acceptance into the Co-Pay Assistance Program for MYOBLOC.**

Patient Information

Patient ID:

Patient Information

Patient Legal Last Name:	Legal First Name:	Middle:	Marital Status: Married ☐ Single ☐
E-mail Address:	Primary Phone: H ☐ C ☐ Other ☐ ( )		Secondary Phone: H ☐ C ☐ Other ☐ ( )
Mailing Address:		P.O. Box: ☐ N/A	
City:	State:	ZIP Code:	MYOBLOC® Dosage (# of vials; vial size):
Are you a U.S. citizen or permanent resident? ☐ Yes ☐ No	Date of Birth (MM/DD/YYYY): / /	Sex: ☐M ☐F	**Site of Care:** Prescriber Name: _____ Facility: _____ Contact: _____ Phone: _____ Fax: _____ Tax ID #: _____ Billing NPI #: _____ Payor ID#: _____ ☐ Unknown

Alternate Contact Information

Alternate

Alternate Contact Last Name:	First Name:	Middle:
Relationship to Patient:	Primary Phone: H ☐ W ☐ Other ☐ ( )	Secondary Phone: H ☐ W ☐ Other ☐ ( )

Financial Information

Financial

Total Annual Household Income:	Household Size:	Current Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Participation is limited to applicants with a household income equal to or below 3.5 times the federal poverty level. The federal poverty level is published in the Federal Register by the Department of Health and Human Services each year.		

Annual Household Income – Money earned by all persons associated with an U.S. Individual Income Tax Return.
Household Size – Number of persons associated with the Annual Household Income and/or who are claimed on an U.S. Individual Income Tax Return.

Insurance Information

Insurance Information

Type of **Primary** Insurance Coverage, check the box below that applies ***(Include copies of insurance cards medical and, if applicable, pharmacy benefit)***:
☐ No Insurance ☐ Medicare ☐ Medicaid ☐ State Medical Aid ☐ Commercial Coverage ☐ Other _____

Prescribed Dose: _____ Units	Diagnosis Code: _____	CPT Code: _____

Name of Primary Insurance:		Cardholder First and Last Name:	Relationship to Applicant:
Member ID #:	Group #:	Primary Phone: ( )	Secondary Phone: ( )

Type of **Secondary** Insurance Coverage, check the box below that applies ***(Include copies of insurance cards medical and, if applicable, pharmacy benefit)***: ☐ No Insurance ☐ Medicare ☐ Medicaid ☐ State Medical Aid ☐ Commercial Coverage ☐ Other _____				
Name of Secondary Insurance: ☐ N/A		Cardholder First and Last Name:		Relationship to Applicant:
Member ID #:	Group #:	Primary Phone: ( )	Secondary Phone: ( )	

Required Documentation

Required Income Documentation

Insurance Information Documentation

- Solstice Neurosciences will contact the patient's insurance provider to verify coverage benefits. Please submit along with this application a copy of the patient's medical insurance card, and if applicable, the patient's pharmacy benefit insurance card.

Mail or Fax the completed and signed application with supporting documents to:

- **Address: 4700 Millenia Blvd., Suite 310, Orlando, FL 32839**
- **Fax: (877) 335-4412**

MYOBLOC is indicated for the treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

IMPORTANT SAFETY INFORMATION

MYOBLOC has a boxed warning related to the distant spread of toxin effect: The effects of MYOBLOC and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms. In unapproved uses, including spasticity in children and adults, and in approved indications, cases of spread of effect have occurred at doses comparable to those used to treat cervical dystonia and at lower doses.

The most frequently reported adverse events with MYOBLOC are dry mouth, dysphagia, dyspepsia, and injection site pain. The vast majority of these adverse events were mild to moderate, temporary, self-resolving, and more common with higher doses. These adverse events may occur within the first week following treatment and may have a duration of several months. In controlled clinical trials, few patients (<1%) stopped treatment due to dry mouth or dysphagia. There is a reduced frequency of dry mouth and dysphagia reported with continued treatment. Dysphagia has commonly been reported by patients treated with all botulinum toxins for cervical dystonia.

Caution should be exercised when administering MYOBLOC to individuals with motor neuron disease (eg, amyotrophic lateral sclerosis), peripheral motor neuropathic diseases (eg, motor neuropathy) or neuromuscular junctional disorders (eg, myasthenia gravis or Lambert-Eaton syndrome). These patients may be at increased risk of clinically significant systemic effects including severe dysphagia and respiratory compromise from typical doses of MYOBLOC. In these patients, rare cases of dysphagia severe enough to cause aspiration pneumonia or to warrant the insertion of a gastric feeding tube have also been reported.

Coadministration of MYOBLOC and aminoglycosides or other agents interfering with neuromuscular transmission (eg, curare-like compounds) should only be performed with caution as the effect of the toxin may be potentiated.

Agreements

Compliance: I understand that if I am accepted into the Co-Pay Assistance Program for MYOBLOC, financial assistance is being provided to help me afford my MYOBLOC therapy, prescribed by my physician for its U.S. FDA-approved indications. In the event I no longer need financial assistance because this medication is no longer being administered, or I have found other means of assistance, I may be removed from the Co-Pay Assistance Program for MYOBLOC.

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand that Solstice may request documentation of household income from me at any time during my participation in the Co-Pay Assistance Program for MYOBLOC to confirm that I meet the program criteria. I understand I am free at any time to switch healthcare providers, practitioners, pharmacies, commercial insurers, or suppliers without affecting my continued eligibility for assistance. I understand my application for assistance does not guarantee funding will be available. I understand if I am awarded financial assistance, it will be provided on an annual basis. I must reapply for assistance each year. Funding in any subsequent year(s) or timeframes is not guaranteed. The Co-Pay Assistance Program for MYOBLOC may be modified or discontinued at any time.

Provision of Assistance: I acknowledge that the Co-Pay Assistance Program for MYOBLOC has been established to help patients in need of financial assistance with their MYOBLOC therapy and who qualify based on the guidelines established by the program. I further agree that if approved for assistance I must maintain my qualification status in order to continue receiving assistance from the Co-Pay Assistance Program for MYOBLOC.

I also agree that if at any time during the approved assistance period, my insurance benefit changes, or my household income changes, I will immediately inform the Co-Pay Assistance Program for MYOBLOC. Such changes may impact my qualification status and the Co-Pay Assistance Program for MYOBLOC may cease providing me assistance or may reduce the amount of assistance allocated to me for the balance of the year.

I understand I cannot participate in the Co-Pay Assistance Program for MYOBLOC if I receive benefits from any Medicare, Medicaid, or Veterans benefit programs or any other state or federal sponsored insurance program. I cannot participate if I am a resident of the Commonwealth of Massachusetts. Furthermore, at any time during the approved assistance period, if I begin receiving benefits from a government program, then I am no longer eligible for participation in this program. Likewise, if I begin receiving government benefits and any portion of the benefits are for retroactive, prescription drug financial assistance, I will be responsible for reimbursing the Co-Pay Assistance Program for MYOBLOC for the same amount of retroactive funding that I received for the medication assistance I received under this program.

Limitation of Liability: I agree that the Co-Pay Assistance Program for MYOBLOC, the program administrators (The Assistance Fund, Inc. and Cardinal Access Services), its employees, officers, and board members; sponsors, sponsors' employees, officers and board members; and donors, donors' employees, officers and board members shall not be liable for any damages of any kind, without limitation, arising out of or in connection with receiving co-pay assistance or other benefits or services provided as a part of this program.

Signature of Patient or Patient's Representative **Date**

Print name of Patient's Representative ***(if applicable)*** **Relationship to Patient** ***(if applicable)***

Patient Authorization to use or release Protected Health Information

I authorize the use and disclosure of my individually identifiable health information ("Protected Health Information") by the Co-Pay Assistance Program for MYOBLOC and the program administrators, The Assistance Fund, Inc., a non-profit organization, and Solstice Neurosciences, LLC reimbursement services administrator, Cardinal Access Services (hereafter "The Co-Pay Providers"). The Co-Pay Providers are authorized to process my application for the Co-Pay Assistance Program for MYOBLOC, to enroll me in this program if I am eligible and funds are available, and to administer this program if I am enrolled.

I authorize my health care provider and insurance company to disclose my Protected Health Information verbally or in writing to the Co-Pay Assistance Program for MYOBLOC and The Co-Pay Providers for use for the purposes stated above. I understand that my Protected Health Information may be subject to re-disclosure pursuant to this authorization. I may withdraw this authorization by mailing or faxing a letter of revocation to the program administrator, The Assistance Fund, Inc., but if I do, it will not have an effect on any actions The Assistance Fund, Inc. took before it received revocation of this authorization. If I revoke this authorization, I will no longer be eligible to receive assistance through this program. This authorization has no expiration date.

I authorize the Co-Pay Assistance Program for MYOBLOC and The Co-Pay Providers to use and disclose my Protected Health Information to financially assist me to obtain my medication. I understand I may request copies of the Protected Health Information described in this authorization.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Print name of Patient's Representative ***(if applicable)*** **Relationship to Patient** ***(if applicable)***

Authorization to Contact Patient

By checking the box below:

☐ The Co-Pay Assistance Program for MYOBLOC may not contact me via text message regarding my assistance.