Print Form

MYOBLOC®
rimabotulinumtoxinB
Injection [5,000 Units/mL]
Service & Support

Patient Assistance Program (PAP)

Enrollment Form for Uninsured Patients
Phone: **1-888-461-2255 (Option 3)** Fax: **1-888-343-3275**
9:00 AM - 6:00 PM Eastern Time Monday - Friday

PLEASE READ: Patient's written consent has been obtained to release patient information to this program to facilitate the insurance verification process: ☐ Yes ☐ No (If no, please obtain consent before submitting this form)

Required Documentation:

- ☐ Completed Application Form: This form must be completed by both the physician and the patient
- ☐ Copy of previous year's tax returns and/or W-2 statement and receipts showing out-of-pocket medical expenses

Patient Information

Patient Name: _____
Address 1: _____
Address 2: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Other Phone: _____
Patient Requesting Assistance: ☐ Yes ☐ No
Patient Has Insurance: ☐ Yes ☐ No

Sex: ☐ Male ☐ Female
Date of Birth: (MM/DD/YY) _____
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced
Number of Persons Dependent upon Primary Income within Family: ☐

Prescriber Information and Shipping Address

Facility Name: _____
Address 1: _____
Address 2: _____
City: _____ State: _____ ZIP: _____
(For Shipping (**No PO Boxes**)
Facility Phone: _____ Facility Fax: _____
Office Hours: _____
(Needed for shipping)

Prescriber Name: _____
State License #: (Required by Law) _____
Office Contact Name: _____
Contact Phone: _____
Contact Email: _____

Treatment Information (To Be Completed by Healthcare Provider)

Site of Service: ☐ Physician's Office ☐ ASC ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other (Please specify) _____

Drug Name: _____
Diagnosis Code 1: _____
Diagnosis Code 2: _____
(ICD-9 Code May Only Be Assigned By Physician)

EMG Code: _____
CPT Code: _____
Date of Service: (If known) _____
Patient Diagnosis: _____
Patient Dosage: Number of Vials: _____ Vial Sizes: _____

PLEASE COMPLETE ENROLLMENT FORM, SIGN AUTHORIZED RELEASE AND FAX TO **1-888-343-3275**

SOLSTICE® NEUROSCIENCES
A US WORLDMEDS COMPANY

MYOBLOC®
rimabotulinumtoxinB
Injection [5,000 Units/mL]
Service & Support

PHYSICIAN/PRESCRIBER AUTHORIZATION AND RELEASE

My signature below certifies that the person named on this form is my patient, and I will be supervising the patient's treatment. I also certify that any medication received from Solstice Neurosciences, LLC ("Solstice") under the Patient Assistance Program (PAP) is medically necessary for the patient named on this form, and will be used only for this patient. I further certify that the dose requested for this patient is appropriate for this patient's medical condition and complies with the Food and Drug Administration (FDA) dosing guidelines. This medication will not be offered for sale, trade, or barter. I certify that no claim for reimbursement for any medication furnished under the Solstice Patient Assistance Program (PAP) will be submitted to the Medicare program, any state Medicaid program, any other healthcare benefit plan, or returned for credit. To the best of my knowledge, this patient has no prescription drug coverage, o patient's insurance has denied coverage for MYOBLOC® (rimabotulinumtoxinB) Injection.

Physician Name (Printed)

Physician Signature Date

PATIENT DECLARATION

In connection with my application for the Solstice Neurosciences LLC ("Solstice") Patient Assistance Program (PAP), I authorize my physician to furnish specific information about my medical condition and financial condition to Solstice, in order to determine my eligibility to participate in the Solstice PAP. I authorize Solstice to use this information only in connection with this program and it will not be released to a third party without my personal authorization. I further understand that once my health information is released to Solstice, it may not be protected by federal health privacy laws. This authorization will remain in effect until I no longer need assistance from the MYOBLOC Patient Assistance Program or until I revoke the authorization by calling a MYOBLOC Patient Assistance Program representative at 888-461-2255 or by sending a fax to 888-343-3275 stating my revocation. This shall not affect any action taken by Solstice in reliance on this authorization before Solstice received my written notice of revocation. By signing below, I certify that the information I have provided on the attached PAP enrollment form is true and correct. I also verify that I have no other health insurance coverage for prescription drugs but not limited to Medicare, Medicaid, employer/retiree-sponsored coverage, state pharmacy assistance program (SPAP), and I will not request any payment from any third party for any drugs furnished to me under this program.

I understand that Solstice sets the criteria for this program and that acceptance into the program now, or at any time, is not a guarantee that I am entitled to receive assistance indefinitely.

By signing below, I attest that the financial information I have provided is complete and accurate and that Solstice may contact me directly to verify my eligibility and to audit any information provided. I also understand that Solstice reserves the right to discontinue, modify or change the program at any time.

Patient Name (Printed)

Patient Signature Date

SOLSTICE® NEUROSCIENCES
A US WORLDMEDS COMPANY