Who is eligible?

All applications are reviewed in accordance with BI Cares program eligibility criteria. To be eligible, you must:

- Be a resident with a physical address within the United States or US Territory
- Have one of the insurance coverage circumstances outlined below:
  - No health coverage
  - Not enough coverage to obtain the medication
- Not have access to alternate sources of coverage or funding for Gilotrif®
- Meet household income guidelines established by BI Cares

What information is needed to submit an application?

The following items should be submitted to the BI Cares Patient Assistance Program – Gilotrif® for the application to be considered complete:

- Complete Sections 1-4 including signatures
- Have a Healthcare Provider complete Sections 5-7 including an original signature

Is financial documentation required?

In order to qualify for free product, you must provide a copy of the most recent federal tax return or other acceptable financial documentation. The financial information and supporting documentation must be for ALL members of the household.
Section 1: Patient Information

First Name: __________________________ Last Name: __________________________

Address: __________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Note: Delivery will be to patient’s address unless otherwise indicated.

Preferred Daytime Phone Number *: (________) —

* I authorize Boehringer Ingelheim Cares Foundation, Inc. (“BI Cares”) and its affiliates, agents, representatives and service providers to use auto-dialers, prerecorded messages, artificial voice messages and messages to contact me at the number I provided above and that these calls may be informational and marketing related and mention the name of BI Cares and of services or products offered by BI Cares, including Boehringer Ingelheim drug products, details about my insurance coverage and my doctor’s name. I understand I am not required to consent to being contacted by auto-dialers, prerecorded messages, artificial voice messages and text messages as a condition of enrollment in BI Cares and if I do not consent, I will not provide my phone number. Standard message and data rates may apply.

Please Send me Text Notifications on Program & Shipment Statuses: Yes No

If Yes and if you would like to receive the text notifications on a different phone number than above, please provide the preferred phone number for text notifications: (________) —

Date of Birth (MM/DD/YYYY): / /

Gender (Please Circle): Male Female

Preferred Language (Please Circle): English Spanish Other: __________________________

Section 2: Patient Financial Information

How many people live in your household (including yourself)?

What is the total household income for a year? $ __________________________

Total patient household assets (excludes first home and car) $ __________________________

Please include proof of income for ALL members of the household:

- Preferred Financial Documentation: IRS Forms 1040, 1040EZ, 1040X, 1099 or copies of all W-2 forms for the Household

- Other acceptable forms of Financial Documentation: SSA-1099, Social Security Benefits Statement, one month of Paycheck stubs dated within the last 90 days, Alimony Statements, Pension Statements or Railroad Retirement Statements

Copies Only – Please do NOT send Original Documents
First Name: ___________________________ Last Name: ___________________________

Section 3: Insurance Information

Have you received disability payments from Social Security for more than 24 months? ................................................................. Yes No

Have you received a denial letter from Medicare Low Income Subsidy?....
If yes, please attach a recent copy of this letter along with your application.

Yes No

Do you have Medicare Part D or Medicare Advantage? ................. Yes No

Do you have Medicaid? ............................................................... Yes No

Do you have prescription drug coverage from a commercial or private health insurer? ................................................................. Yes No

Do you receive Veterans Affairs Benefits? ................................. Yes No

Section 4: Patient Attestation & HIPAA Authorization

Patient Attestation
The information you, the Patient, provides as part of this BI Cares Patient Assistance Program – Gilotrif® application (“Application”) will be used by Boehringer Ingelheim Cares Foundation, Inc. (“BI Cares”) and its affiliates, agents, representatives and service providers to:

1. process this Application and verify the information contained in this Application,
2. administer, analyze, and improve the BI Cares Patient Assistance Program – Gilotrif® (“Program”),
3. improve and tailor our products and services to better serve you,
4. communicate with you about your experience with the Program, and/or
5. send you materials and other helpful information and updates relating to BI Cares programs (“Services”).

By signing below, you, the Patient, attest and certify that:

- The information provided in this Application and any additional information provided as part of the Application process is current, complete, and accurate to the best of your knowledge.
- You cannot afford the medication requested and (1) have no coverage or (2) have no coverage for this medication or (3) have coverage for the medication but have an out-of-pocket expense you cannot afford.
- You will not seek reimbursement for any medication dispensed from the Program.
- You will notify the Program immediately if the medication requested is no longer medically necessary for your treatment or if your insurance or financial status has changed.

[Continued on Next Page]
First Name: ___________________________ Last Name: ___________________________

In addition, by signing below, you, the Patient, understand and agree that:

- Any medication supplied as a result of this Application is for your use only, and shall not be sold, traded, bartered, transferred, returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to you.
- The information provided in this Application is subject to random audits and verification. During such audits and verification processes, you may be asked for additional supporting documentation.
- BI Cares may change this program at any time and also reserves the right to terminate your enrollment at any time due to lack of eligibility or related factors.
- Additional information may be requested to process this application.
- The medication made available to you under the Program may be denied if you do not fully cooperate with efforts made to verify the information provided in this application, or if you do not take steps to secure alternative means of prescription coverage that are available to you, after you become aware of such alternatives.
- BI Cares is not obligated to verify any of the information contained in this Application or to confirm other medications that you are taking.

HIPAA Authorization

By signing below, you, the Patient, hereby authorize:

- Your physicians, health care providers, pharmacy providers, and health plans to disclose to BI Cares and its affiliates, agents, representatives and service providers (“Recipients”) your individually identifiable health information, which may include information related to your medical condition, treatment, care management, health insurance, medication history, and prescriptions (“Health Information”).
- The Recipients to access, obtain, use, disclose, receive, and maintain your Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of, or determining eligibility under, other patient assistance resources, and conducting the additional Services described above.

In addition, by signing below, you, the Patient, understand and agree that:

- This authorization is voluntary, but if you do not sign it, you will not be able to participate in the Program. Your physicians and healthcare providers may not condition the provision of your treatment on your signing this authorization.
- Information released under this authorization may no longer be protected by state and federal law.
- You may withdraw your authorization at any time by mailing a written withdrawal to BI Cares at the address below, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- If you do not withdraw your authorization, this authorization will be in effect for one year from the date of enrollment if approved for the program.
- Your pharmacy may receive compensation in exchange for reports containing your information.

__________________________  _________________
Patient (or Authorized Representative) Signature  Date

Mail or Fax the Complete Application to:
BI Cares Patient Assistance Program – Gilotrif®
P.O. Box 5697, Louisville, KY 40255
Fax: 1-855-297-5905

Contact us if you need help:
BI Cares Patient Assistance Program – Gilotrif®
Phone: 1-855-297-5904  Fax: 1-855-297-5905

Hours of Operation:
Monday – Friday
8:30 AM – 6:00 PM ET

05/2019
Section 5: Prescriber Information

Prescriber Name: ____________________________ NPI: ____________________________
Specialty: ____________________________ SLN #: ____________________________ SLN Exp. Date: ____________________________
Site/ Facility Name: ____________________________ Office Contact Name: ____________________________
Address: ____________________________
City: ____________________________ State: ____________________________ Zip Code: ____________________________
Office Phone: ____________________________ Office Fax: ____________________________

Section 6: Prescription & Medication Information

First Name: ____________________________ Last Name: ____________________________ Date of Birth: __/__/____
Gilotrif® (circle one): 20mg 30mg 40mg Days Supply: 30 days
Directions: ____________________________ Refills: ____________________________
Medication Allergies? Yes No If Yes, please list all drug allergies: ____________________________

Current Medications (please list):
* A separate prescription form may be attached to this application and a separate form should be attached if required by federal and state law.

The information you, the Prescriber, provides as part of this BI Cares Patient Assistance Program – Gilotrif® application (“Application”) will be used by Boehringer Ingelheim Cares Foundation, Inc. (“BI Cares”) and its affiliates, agents, representatives and service providers to (1) process this Application and verify the information contained in this Application, (2) administer, analyze, and improve the BI Cares Patient Assistance Program – Gilotrif® (“Program”), (3) improve and tailor our products and services to better serve you, (4) communicate with you about your experience with the Program, and/or (5) send you materials and other helpful information and updates relating to BI Cares programs (“Services”).

By signing below, you, the Prescriber, attest and certify that:
- The information provided in this Application and any additional information provided as part of the Application process is current, complete, and accurate to the best of your knowledge.
- To the best of your knowledge, the patient identified in this Application cannot afford the medication requested and (1) has no coverage or (2) has no coverage for the medication or (3) has coverage for the medication but has an out-of-pocket expense he/she cannot afford.
- You will not seek reimbursement for any medication dispensed from the Program.
- You will notify the Program immediately if the medication requested is no longer medically necessary for this patient’s treatment or if you become aware that your patient’s insurance or financial status has changed.
- You have a signed copy on file of your patient’s current and completed HIPAA Authorization, or any other authorization or consent required by law, so that you may share patient health information with the Program, including BI Cares and its affiliates, agents, representatives and service providers.

In addition, by signing below, you, the Prescriber, understand and agree that:
- Any medication supplied as a result of this Application is for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to your patient.
- The information provided in this Application is subject to random audits and verification.
- BI Cares may change this program at any time; BI Cares also reserves the right to terminate your patient’s enrollment at any time due to lack of eligibility or related factors.

Fax the Complete Application to: 1-855-297-5905

Prescriber Signature (Original – Stamps NOT ACCEPTED) ____________________________ Date ____________________________
Application Page 4 of 5
Section 7: Other Coverage Information

If your patient has prescription coverage, the following information may be helpful in determining your patient’s eligibility for the BI Cares Patient Assistance Program:

Name of Preferred Specialty or Dispensing Pharmacy: ______________________________

Was the product covered by the patient’s prescription drug coverage? (Please Circle):

- Yes
- No
- N/A (Patient is Uninsured)

- Please provide the name of the prescription plan: ______________________________

- If No, was a formulary exception or prior authorization submitted & denied? Yes No

- If Yes, was an appeal submitted and denied? ________________________________ Yes No