BAUSCH Health

Patient Assistance Program Application

Thank you for your interest in the Bausch Health Patient Assistance Program (Bausch Health PAP).
This program is designed to provide assistance and access to individuals in need of products made available through the Bausch Health PAP. All applications are reviewed on a case-by-case basis and there is no cost to apply.

ELIGIBILITY

You may be eligible for the program if you:

- Are a legal United States resident
- Have a valid prescription from a licensed U.S. healthcare professional for a product made available through the Bausch Health PAP
- Do not have insurance coverage for the prescribed Bausch Health product
- Are being treated as an outpatient
- Meet the pre-defined eligibility requirements and total annual household income requirements
- If you are applying for assistance and are a Medicaid patient, please download the "Application for Medicaid-Only Patients" available on the web page below

For full eligibility requirements, please visit BauschHealthPAP.com

APPLICATION INSTRUCTIONS

Patient Instructions:

1. Complete the Patient Information and Insurance Information Sections on page 2.
2. **Read and sign the Patient Authorization and Certification on page 3.**
3. Have your prescriber complete pages 4, 5, 6 and sign Prescriber Certification on page 6.
4. Attach a copy of your medical and prescription insurance cards (front and back).
   Special note: If a copy of your medical and prescription card and the pharmacy statement is not provided, your application will be incomplete.
5. Attach a statement from your pharmacy showing what your cost would be to purchase this medication and check the box on page 2 that this pharmacy documentation has been included with the application.

Please DO NOT send Medical Records. Only send in application.

NOTE: IF REQUIRED INFORMATION INDICATED WITH AN ASTERISK IS NOT PROVIDED, THE APPLICATION WILL BE PUT ON HOLD UNTIL ALL MISSING INFORMATION IS RECEIVED.

Prescriber Instructions: Do not include the Patient Medical Record with the application it is not necessary.

1. **Ensure the patient fully completes** pages 2 and 3 and that copies of their insurance and prescription cards are attached.
2. Please work with the patient to ensure that they include a copy of their out-of-pocket (OOP) costs with the application. The OOP will detail the total patient out-of-pocket responsibility for the prescription. The OOP can be obtained from a pharmacy. We must have a copy with this Pharmacy information included or the application will be incomplete.
3. Complete **Product Selection** Information on page 4.
4. Complete the valid prescription(s) with the physician's signature on page 5. Accepting electronic/stamped/docu-signed signatures. **Stamped signatures are not allowed for controlled substances.**
5. **Sign Prescriber Certification on page 6.**

NOTE: IF REQUIRED INFORMATION INDICATED WITH AN ASTERISK IS NOT PROVIDED, THE APPLICATION WILL BE PUT ON HOLD UNTIL ALL MISSING INFORMATION IS RECEIVED.

TO APPLY

Fax or Mail the completed application form and any requested documentation to:

FAX: 844-705-0160 ***Or*** **MAIL:** BAUSCH HEALTH PATIENT ASSISTANCE PROGRAM
P.O. Box 991624
Louisville, KY 40269

For program questions please contact
BAUSCH HEALTH PATIENT ASSISTANCE – 833-862-8727

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PATIENT INFORMATION (All information noted with an * is required information)

*First Name	*Last Name	
*Street Address		
*City	*State	*ZIP Code
*Primary Phone ☐ Home ☐ Mobile	Secondary Phone ☐ Home ☐ Mobile	

By checking yes below, I authorize the Bausch Health Patient Assistance Program (BHPAP) to send text messages to my cell phone to convey important information related to my application status or potential shipments. I understand that standard text messaging rates will apply to any messages received from BHPAP. I also understand that I or BHPAP may revoke this permission in writing at any time. I further agree that in the event my cell phone number changes, I will inform the program. By checking Yes here I am authorizing program communications to be received via text. ☐ Yes ☐ No

* Last 4 digits of the Social Security Number	*U.S Resident ☐ Yes ☐ No	*Gender ☐ Male ☐ Female
If you do not have an SSN, please attach other documentation showing proof of legal US residency.	*Date of Birth (mm/dd/yy)	
Email	Did you include documentation from your pharmacy showing your cost to purchase this medication at the pharmacy? ☐ Yes ☐ No IF NO, THEN THIS DOCUMENTATION MUST BE INCLUDED WITH THE APPLICATION FOR IT TO BE COMPLETE.	
*Check Number of People in Household (INCLUDE SELF) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+		

*ANNUAL Household Income $ Do not include income from alimony, child support, and food stamps ☐ *Check here if you have no income.

Patients who have income levels consistent with Medicaid eligibility may be eligible for the PAP only if: (1) they provide proof of application and denial for Medicaid coverage, or (2) they provide proof they are covered by a Medicaid plan that provides no coverage for the relevant Bausch Health product(s).

INSURANCE INFORMATION (All information noted with an * is required information)

☐ ***I Do Not Have Health Insurance or Prescription Coverage** (if checked, go to page 3)

***Medicare** (select all that apply) *"If you currently have Medicare Part A and B only, please make sure that you answer Yes to the insurance question as "Yes" for having insurance: Your Part B is your medical insurance."*

☐ ***Medicare Part A**?	☐ ***Medicare Part B**?	☐ ***Medicare Part C** (Medicare Advantage)?
*Insurer Name		
*Insurer Phone	*Medicare Policy ID #	

☐ ***Medicare Part D**? **If you received a denial letter for Low Income Subsidy, please attach a copy with your application.**

*Part D Plan Name	*Group ID #	*Part D Plan Phone
*Part D Policy ID #	*Rx BIN #	*Rx PCN #

***Other Government Insurance**

☐ *Medicaid?	☐ *Veterans Affairs (VA) Benefits?	☐ *Other State/Federal Patient Assistance Program?
*Plan Name	*Phone	
*Policy ID #	*Rx BIN #	*Rx PCN #

*Any other benefit program that helps pay for prescription drugs? ☐ Yes ☐ No

☐ ***Private Insurance** (such as HMO or PPO) ***Does** your policy include Prescription Drug Coverage? ☐ Yes ☐ No

*Insurer Name	*Insurer Phone	
*Cardholder Name	*Cardholder Date of Birth (mm/dd/yy)	
*Relationship to Cardholder	*Group ID #	
*Policy ID #	*Rx BIN #	*Rx PCN #

For program questions please contact
BAUSCH HEALTH PATIENT ASSISTANCE – 833-862-8727

PATIENT AUTHORIZATION FOR USE and DISCLOSURE of PERSONAL HEALTH INFORMATION (Patient must read and sign below)

I hereby consent to allow and authorize Bausch Health Pharmaceuticals Inc., and its affiliates, agents, and contractors, including the administrator of the Bausch Health Patient Assistance Program ("Bausch Health PAP"), and the dispensing pharmacy or distributor of Bausch Health products (collectively, "Bausch Health") to use and/or disclose my personal health information ("PHI") including the information in this form and my dispensing information to any third party engaged to assist Bausch Health in the administration of the Bausch Health PAP, including seeking providers of alternate sources of funding for prescription drug costs for Bausch Health products, which may exclude me from participation in the Bausch Health PAP. I understand that this information will be used to determine my eligibility for participation in the Bausch Health PAP and to administer the program, and my participation in the program, and that Bausch Health reserves the right at any time for any reason to contact me and to request additional information. I authorize my physician, pharmacy and my health plan(s) and individuals affiliated with them to disclose my PHI including information related to my condition and information on this application form. I authorize Bausch Health to contact any of these persons or entities on my behalf in order to collect my PHI or any other personal information necessary to complete this application or to determine if I am eligible for benefits under the Bausch Health PAP. I understand that my PHI disclosed in this application or in relation to this application may no longer be protected by any privacy laws and may be re-disclosed by Bausch Health for the purposes described here. I understand that I am not required to give my consent or authorization, and that while my refusal will not impact my health care providers' treatment of me, if I do not provide consent, Bausch Health will not be able to evaluate my eligibility for the Bausch Health PAP.

AUTHORIZATION TO USE AND RELEASE FINANCIAL INFORMATION (Patient must read and sign below)

I, the applicant named below, understand that I am providing 'written instructions' to Bausch Health and its vendor, J. Knipper and Company, Inc., under the Fair Credit Reporting Act authorizing J. Knipper and Company, Inc. on behalf of Bausch Health to obtain information from my credit profile or other information from Experian Health or any other credit reporting agency. I authorize Bausch Health and its partnered provider, J. Knipper and Company, Inc. to obtain such information solely for determining financial qualifications for the Bausch Health PAP. My credit profile or other information received from Experian Health and/or any other credit reporting agency will be used to estimate my household size and income as part of the process to decide if I am eligible to participate in the Bausch Health PAP. If I am deemed ineligible, and upon my request, Bausch Health will provide me contact information of the credit reporting agency that provided my credit profile and/or other information. I may call the Bausch Health Patient Assistance Program at 1-833-862-8727 for this contact information. I understand that I must affirmatively agree to the terms in this notice by signing below to proceed in the Bausch Health PAP financial screening process.

APPLICANT CERTIFICATION (Patient must read and sign below)

By signing below, I certify that the information provided in this application, including all copies of documentation, if applicable, is complete and accurate, and that I am authorized to sign this application. I understand that benefits under the Bausch Health PAP will terminate if the program determines that any of the information supplied was not truthful or accurate. I understand that completing this application does not ensure that I will quality for the Bausch Health PAP. I also verify that I am not currently receiving benefits or coverage for the product(s) selected on page 4 from Medicaid, Medicare, or any other public or private insurance or assistance program. I acknowledge and agree that I shall not report or count the value of any product provided to me under the Bausch Health PAP toward any insurance deductible or, if I am enrolled in Medicare Part D, as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit. In addition, I will not seek reimbursement from or submit claims to any insurance provider or plan, including Medicare Parts B or D, or Medicaid, for the costs of any free product provided by the Bausch Health PAP. For the remainder of my eligibility period I will continue to receive all my prescriptions for the selected products from the Bausch Health PAP. I also agree that I will contact Bausch Health if any of the information regarding my prescription drug coverage or insurance changes. I understand that Bausch Health and any third party engaged to assist in the administration of the Bausch Health PAP has the right to verify my eligibility, including the right to audit any information provided by me or my physician. I understand that the parties disclosing or receiving my data pursuant to this authorization may receive financial remuneration from Bausch Health. I also understand that Bausch Health has the right to contact me directly by phone, mail, or email, if my email address was supplied on page 2, and to confirm product delivery and to revise, change, or terminate this program at any time. I understand that Bausch Health reserves the right to modify or discontinue the program or terminate any benefits I receive at any time and without notice. I authorize Bausch Health to forward the prescription associated with this application to a dispensing pharmacy on my behalf. I understand that the Bausch Health PAP is not insurance.

SIGN Applicant's Signature _____ Date _____

ALTERNATE/AUTHORIZED PATIENT REPRESENTATIVE (If applicable)

If additional authorized patient representative required, attach information to application with information below.
Complete if Bausch Health PAP may address insurance or other financial questions or other application-related issues with my authorized representative on my behalf.

Patient's Signature		**Date**
Authorized Patient Representative Name		
Relationship to patient	Fax #	Primary Phone #
Email		

For program questions please contact
BAUSCH HEALTH PATIENT ASSISTANCE – 833-862-8727

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PRODUCT INFORMATION (To be completed by the Prescriber)

Patient Name	*Date of Birth (mm/dd/yy)

Select from product listing below. Eligible patients may be able to receive product through this program for up to one year, up to a 90 day supply per dispense, as long as a valid prescription remains on file.

SHIP TO (required) ☐ **Patient's Home** ☐ **Prescribing Physician's Office** **If no selection is made, the shipment will go directly to the patient.**

BAUSCH HEALTH PHARMACEUTICALS PRODUCTS

☐	**APLENZIN®** (bupropion hydrobromide), Extended-Release Tablets, ☐ 174 mg ☐ 348 mg ☐ 522 mg
☐	**CUPRIMINE®** (penicillamine) 250 mg Capsules
☐	**DEMSER®** (metyrosine) 250 mg Capsules
☐	**SYPRINE®** (trientine hydrochloride) 250 mg Capsules
☐	**TASMAR®** (tolcapone) 100 mg Tablets
☐	**ZELAPAR®** (selegiline hydrochloride) 1.25 mg Orally Disintegrating Tablets

SALIX PHARMACEUTICALS PRODUCTS

☐	**XIFAXAN®** (rifaximin) Tablets, for Oral Use, 550 mg
☐	**RELISTOR®** (methylnaltrexone bromide) 150 mg Tablets, for Oral Use, 90-count
☐	**RELISTOR®** (methylnaltrexone bromide) injection, for subcutaneous use (7 single-dose pre-filled syringes per carton) ☐ 8 mg/0.4 mL ☐ 12 mg/0.6 mL
☐	**TRULANCE®** (plecanatide) 3 mg Tablets
☐	**UCERIS®** (budesonide) 2 mg Rectal Foam

ORTHO DERMATOLOGICS PRODUCTS

☐	**ARAZLO®** (tazarotene) Lotion, 0.045%
☐	**BRYHALI®** (halobetasol propionate) Lotion, 0.01% ☐ 60 g ☐ 100 g for Topical Use
☐	**DUOBRII®** (halobetasol propionate and tazarotene 0.01%/0.45%) 100 g for Topical Use
☐	**JUBLIA®** (efinaconazole) Topical Solution, 10% ☐ 4 mL ☐ 8 mL
☐	**LUZU®** (luliconazole) Cream, 1% for Topical Use
☐	**NORITATE®** (metronidazole cream) Cream, 1% for Topical Use Only
☐	**SILIQ®** (brodalumab) Injection 210 mg/1.5mL (1 box of 2 syringes)
☐	**TARGRETIN®** (bexarotene) 75 mg Capsules, for Oral Use
☐	**TARGRETIN®** (bexarotene) Gel 1%

Before prescribing any product on the above list, please see full Prescribing Information, including any Boxed Warning, Medication Guide, and/or Patient Information, available at BauschHealthPAP.com or call Bausch Health Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.

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PHYSICIAN/PRESCRIBER MUST COMPLETE INFORMATION (All information noted with an * is required information)
COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW. PLEASE PRINT IN LEGIBLE CAPITAL LETTERS.

THIS IS THE PRESCRIPTION. **PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION, UNLESS FOR A CONTROLLED SUBSTANCE OR AS REQUIRED BY YOUR STATE LAW.**

*PATIENT FIRST NAME	M.I.	*LAST NAME

*DATE OF BIRTH (M M / D D / Y Y Y Y)	*PATIENT PHONE ☐ Home ☐ Mobile

*STREET ADDRESS

*CITY	*STATE	*ZIP CODE

*PRODUCT NAME	*STRENGTH	*QUANTITY (UP TO 90 DAYS)	*DIRECTIONS	*REFILL TIMES 1 2 3 Other
				☐ ☐ ☐ ☐
*PRODUCT NAME	*STRENGTH	*QUANTITY (UP TO 90 DAYS)	*DIRECTIONS	*REFILL TIMES 1 2 3 Other
				☐ ☐ ☐ ☐
*PRODUCT NAME	*STRENGTH	*QUANTITY (UP TO 90 DAYS)	*DIRECTIONS	*REFILL TIMES 1 2 3 Other
				☐ ☐ ☐ ☐

*ALLERGIES: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Other

*MEDICAL CONDITIONS: ☐ None ☐ Asthma ☐ Glaucoma ☐ Heart ☐ High BP ☐ Ulcer ☐ Other

*CURRENT MEDICATION(S) BEING TAKEN BY THE PATIENT:

PHYSICIAN/PRESCRIBER MUST COMPLETE, SIGN AND DATE

*PHYSICIAN'S FIRST NAME	M.I.	*PHYSICIAN'S LAST NAME

*PRESCRIBER NPI #	*STATE LICENSE #	DEA # Required for controlled substance products

*NAME OF FACILITY/SITE

*STREET ADDRESS 1

STREET ADDRESS 2

*CITY	*STATE	*ZIP CODE

*OFFICE PHONE	EXT.
*SECURE FAX	*PROFESSIONAL DESIGNATION
OFFICE CONTACT NAME	E-MAIL ADDRESS

PHYSICIAN/PRESCRIBER ATTESTATION

I certify that this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize the Bausch Health PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. I understand that Bausch Health PAP reserves the right to modify or discontinue this program at this facility/practice, or terminate assistance at any time and without notice.

SIGN *Physician's/Prescriber's Signature _____ *Date ☐☐ ☐☐ ☐☐☐☐ (M M / D D / Y Y Y Y)

THIS FORM SHOULD NOT BE TAMPERED WITH OR REVISED IN ANYWAY. Accepting electronic/stamped/docu-signed signatures. Stamped signatures are not allowed for controlled substances.

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SHIPPING INFORMATION (Complete if shipping to prescriber's office and information is different from Prescriber)								
Ship to Site/Facility Name	NPI # (if different from above)							
Shipping Address								
City	State	Zip Code						
Delivery Contact Name	Phone							

PRESCRIBER CERTIFICATION

I have determined, based on my independent clinical judgment, that the above-named patient should be treated with the Bausch Health product(s) identified on page 4. By signing below, I confirm that the patient is under my care on an outpatient basis; I will not charge the patient any fee for enrollment or other activities associated with the patient's participation in the Bausch Health PAP; I will not charge the patient for any professional services associated with the product(s) that are not covered by the patient's insurance provider or plan, or when the patient's costs associated with the prescribed product(s) represents a financial hardship and assistance has been approved by the Bausch Health PAP; I will not make any claim to any third party payer (e.g., Medicaid, Medicare, public or private insurance, etc.) for payment of product provided by the Bausch Health PAP; I will not sell, trade or return for credit the products(s) provided under the Bausch Health PAP; and I am not prohibited from participating in federally funded health care programs nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General. To the best of my knowledge, the patient does not have affordable third-party insurance coverage for the selected product(s) through, for example, an HMO, private insurance, a State pharmacy program, Medicare, Medicaid, or Veterans Assistance, and the patient meets all other Bausch Health PAP eligibility requirements. By signing this form, I authorize Bausch Health PAP as my designated agent on behalf of the patient, to forward the prescription for the product(s) selected and presented herein by fax or other mode of delivery to the Bausch Health PAP dispensing pharmacy or distributor for fulfillment and/or dispensing. By including my email address on page 5, I agree to receive communication related to Bausch Health PAP by email.

By including my fax number on page 5, I acknowledge that any communication by, or on behalf of, the Bausch Health PAP in relation to this application or the participation of the applicant in the Bausch Health PAP delivered by facsimile machine to that fax number is not an unsolicited advertisement and I authorize the Bausch Health PAP, and anyone acting on its behalf, to communicate with me and my office through such means for that purpose.

SIGN **Prescriber's Signature** _____ **Date** _____

THIS FORM SHOULD NOT BE TAMPERED WITH OR REVISED IN ANYWAY. Accepting electronic/stamped/docu-signed signatures.

Physician's signature or electronic signature is required. **Stamped signatures are not allowed for controlled substances.**

Bausch Health Patient Assistance Program benefits, rules, and product availability are subject to change at any time without prior notification.

You are encouraged to report negative side effects of prescription drugs to FDA at www.fda.gov/Safety/MedWatch, or call 1-800-FDA-1088.

Please see full Prescribing Information, including any Boxed Warning, Medication Guide and/or Patient Information, available at BauschHealthPAP.com or call Bausch Health Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.