NapoCares™ Patient Assistance Program Application

PO Box 259
Acworth, GA 30101-0259
Telephone: (888) 527-NAPO (6276) ■ Fax: (866) 468-2420 ■ NapoCares@medcommtech.com
www.mytesi.com/mytesi-savings.html

Internal ID No._____

About this program: The NapoCares Patient Assistance Program ("NapoCares") is designed to provide Mytesi™ (crofelemer) Delayed-Release Tablets to uninsured patients for whom a medical need has been established, who cannot afford the cost of therapy, who meet the maximum income requirements adjusted by household size and have no other insurance coverage options available to access Mytesi.

Instructions for Application

Patient eligibility: Can I apply to this program? (You must meet all of these requirements)

- My doctor has prescribed Mytesi
- I am a permanent, legal resident of the United States
- I do **NOT** have prescription drug insurance coverage
- I am **NOT** 65 years or older and/or eligible for Medicare, Medicaid, or Veterans Administration benefits
- My total GROSS (before deductions) yearly household income is equal to or less than two (2) times the federal poverty level adjusted by household size

How do I apply?

The following documents MUST be included in the NapoCares application to determine eligibility for participation in the program:

Patient:

☐Completed and signed Authorization for Use or Disclosure of Health Information Form
☐Patient Section of the Application Form
☐Proof of Income

Physician:

☐Physician Section of the Application Form

IMPORTANT: Patient must meet all program eligibility requirements in order to receive Mytesi at no cost from the NapoCares Patient Assistance Program.

What are examples of Proof of Income documents?

- Copy of current pay stubs or earnings statements
- Copy of last year's Federal Income Tax Return
- Copy of Social Security income yearly benefit statement
- Copy of Statements of interest, dividends, or other income
- Copy of W-2 or 1099 forms
- Copy of Unemployment Benefit Statement

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Patient Information

Patient Name: (Last)_____(First)_____(MI)_____

Male: ☐ Female: ☐ Date of Birth: _____/_____/_____ Social Security No.: _____

Address (PO Box not acceptable): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Number of Family Members in Household: ____

Annual Household Income (Total Combined Yearly Income for All Family Members): $_____

Patient Assistance Application Form – Patient Section

By my signature below, I confirm that I am a resident of the US and that I understand and that I authorize NapoCares and any entity that may be contracted to be the Program Administrator ("Administrator") of NapoCares to receive and to have access to the following information: (1) information contained in this application, (2) information on the prescription medications that my healthcare provider has provided or will provide me, and (3) other information ("Information") that NapoCares or the Administrator may obtain about me in managing the NapoCares Program.

By my signature below, I further authorize NapoCares to use the information in the following manner: (1) to review my application and to contact me or my healthcare provider, as necessary, to conduct such review, (2) for purposes relating to the management of the NapoCares Program, and (3) for NapoCares internal purposes involving patient assistance programs and charitable programs generally. I understand that this information will not be shared with other parties, but that certain nonpersonal portions of the information (for example, general location, age, gender) may be shared with other parties for purposes of managing NapoCares. I understand that I have the right to revoke this Authorization at any time by sending written notice to NapoCares at the address set forth in this application. If I revoke this Authorization, I will no longer be eligible for the services provided by the NapoCares Program. Canceling this Authorization will prohibit disclosures of my personal information after the date the cancellation letter is received and processed but will not affect disclosures made before that time.

I authorize any pharmacy and/or healthcare provider who is in possession of my health information to use and/or disclose to NapoCares and the Administrator all information relating to my participation in the program. I understand that if my information is disclosed in this manner by a pharmacy or healthcare provider federal privacy laws may no longer protect the information from further disclosure.

I certify that I am not 65 years or older. I certify that I am not eligible for Medicare and I am not currently receiving any benefits under Medicare. I understand that when I turn 65 years old or become eligible for Medicare, I will no longer be eligible for this program and I agree to promptly notify NapoCares of my age and/or eligibility for Medicare at that time. I certify that the information I have set forth in this application is true, correct, and complete, and I agree to abide by the rules, procedures, and conditions of this program. I understand that eligibility under the NapoCares Program is subject to approval by NapoCares and/or the Administrator and that application to the NapoCares Program does not guarantee inclusion in the NapoCares Program. I understand that the NapoCares Program may be changed or terminated at any time without prior notice.

_____ _____
Signature of Patient/Guardian/Patient Representative Date

_____
Patient Name (please print)

_____ _____
Name of Guardian/Patient Representative (if applicable) Relationship to Patient

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Patient Assistance Application Form – Physician Section

Physician Name: _____ Specialty: _____

Primary Office Contact: _____ Email: _____

Street Address (PO Box not acceptable): _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

DEA #: _____ License #: _____

Mytesi™ (crofelemer) Delayed-Release Tablets

Dose/Frequency: _____

Estimated Duration of Therapy: _____

Diagnosis: _____

I certify that, to the best of my knowledge, the patient for whom this drug is requested meets the eligibility requirements and has an established medical need for Mytesi. I agree to permit NapoCares, upon reasonable notice to me, to audit my records to substantiate that drugs requested through this program were distributed at no charge to the patient, and that no insurance or reimbursement claim has been submitted with respect to such drug.

Physician Signature:_____ Date: _____

PLEASE NOTE: The Patient ID Number located in the top right corner of each form is used to designate the patient to whom the shipment of Mytesi is intended and will be referenced on the outside of each shipment package. If approved, the drug will be shipped to the requesting physician within 3 to 5 business days upon receipt of the completed application forms.

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1. Overview. NapoCares is designed to provide Mytesi to uninsured patients for whom a medical need has been established, who cannot afford the cost of therapy, who meet the maximum income requirements adjusted by household size and have no other insurance coverage options available to access Mytesi.

2. Definitions. For the purpose of this Policy Statement and NapoCares, the following definitions shall apply:

"Patient":	One on whose behalf an application has been submitted for Benefits under NapoCares.
"Applicant":	A person who submits an application for Benefits under the program.
"Beneficiary":	An Applicant whose application for access to Mytesi at no cost has been granted in full or part by NapoCares.
"Benefits":	Mytesi Delayed-Release Tablets that are provided by NapoCares.
"You":	The Applicant and/or a Beneficiary, as appropriate from the context of this use.

3. Signatures Required. In order to be considered for Benefits under NapoCares, both You and the prescribing physician must complete and sign the appropriate sections of the application form. If the Patient is younger than 18 years, the Patient and his or her parents shall jointly submit and execute the application. Regardless of the age of the Patient, if any person described in the following clauses exists, all such persons must join in submitting and executing the application:

   a) any person that has legal custody or guardianship over the Patient; or
   b) any person that has the legal right/power to act on behalf of the Patient; or
   c) any person that claimed (or can claim) the Patient as a dependent on his/her most recent (or next) federal income tax return.

At the request of NapoCares, a person described in subparagraphs (a) – (c) of this paragraph may be required to provide proof of his or her relationship to the Patient. We reserve the right to request information that supports the financial status of household members other than the Applicant.

4. Access to Information. Your application for Benefits must allow access to the financial, medical, and other information about You required pursuant to the application. In order for NapoCares to receive certain medical information about You in your application, the Health Insurance Portability and Accountability Act of 1986 and the related Privacy Rule 45 CFR Parts 160 and 164 (collectively "HIPAA") requires NapoCares to obtain your written authorization. If You do not sign the authorization, NapoCares cannot process Your application and You cannot participate in NapoCares.

5. Eligibility. For purposes of this Policy, the determination of whether a person can afford Mytesi is considered with respect to the individual and, if applicable, family/household members and/or any other person having legal responsibility for the Patient (if the Patient is a minor or a dependent adult). NapoCares is intended for Patients who are financially disadvantaged and have no other insurance coverage options that would enable the Patient to access Mytesi. Only Patients whose annual **household** income (all household members' incomes must be included) that is equal to or below twice the current federal poverty level adjusted by household size are eligible for participation in NapoCares for Mytesi at no cost.

6. US Residents Only. Only Legal US Residents are eligible for Benefits under NapoCares.

7. Limit on Supply. A maximum of 1 initial prescription fill and 5 prescription refills of Mytesi over a 6-month period may be awarded to a Beneficiary for each application submitted. Prescribing physicians and Patients must reapply if additional supplies are required.

8. No Right to Assistance. Neither a Patient nor an Applicant for Benefits under NapoCares has a legal right to receive assistance from NapoCares. Any award of Benefits from NapoCares will involve the assessment of many criteria among potentially qualified Patients and Applicants. Therefore, we reserve the right to grant or deny an application, in whole or in part, on the basis of such criteria as we deem appropriate. In particular, the fact that an Applicant or Patient may be granted an award of Benefits at one time does not mean that the Applicant or Patient is entitled to, or will be granted an award of Benefits at any time.

9. Distribution. NapoCares uses contracted partners for all of its distribution activities, including distribution of Mytesi. NapoCares is not responsible for the activities of its contracted distributors and any delays in shipment or other problems that might occur with the delivery of Mytesi is solely the responsibility of the contracted distributor. Mytesi will be shipped to the requesting physician's office and dispensed by the physician.

10. Drug Shortage. NapoCares will attempt to ensure that sufficient quantities of Mytesi are available to provide You with the amount of drug that You may be awarded under NapoCares. In the event that a shortage of drug exists at any time during a period of time for which You have been awarded drug under NapoCares, NapoCares will give You written or verbal notice of that shortage.

11. Waiting Lists. NapoCares may receive numerous applications resulting in request for more Mytesi than is available to the program. Therefore, NapoCares may not be able to approve all applications for Benefits. Moreover, a waiting list of Applicants may accrue, which may delay processing applications until a sufficient supply of Mytesi becomes available to the program.

12. Right to Modify Benefit. We, during the time period of any award to Beneficiary, reserve the right to review the award and/or the Patient's medical and financial situation. Based on that review, we reserve the right to increase, decrease or terminate Benefits previously awarded to You.

13. Additional Restrictions. In the course of reviewing an application and/or administering an award of Benefits under NapoCares, we reserve the right to impose such other conditions and/or require that You provide such other in information and/or that You take such actions as we deem appropriate.

14. No Warranties. NapoCares does not make any warranties, either expressed or implied, concerning any aspect of the NapoCares.

15. Termination of Program. NapoCares may be terminated, without prior notice, at any time.

