Patient Assistance Program Application

P.O. Box 8308, Somerville, NJ 08876

RedHill Biopharma
Patient Assistance Program

What is the RedHill Biopharma Patient Assistance Program (PAP)?

- The RedHill Biopharma PAP provides eligible patients with free RedHill medications for up to one (1) year
- Your medication may be sent to your home or the home of a family member (e.g., residential address)
- **The Program is neither a government program nor an insurance plan and can be changed or stopped by RedHill Biopharma at any time or for any reason**

You may be eligible for the RedHill Biopharma PAP if you:

1. Are a U.S. citizen living in one of the 50 states, the District of Columbia, or Puerto Rico
2. Meet certain household income limits
   - Visit **https://www.redhillbio.com/our-programs/patient-assistance-program** or call 1**-844-RDHL-PAP/1-844-734-5727** for details
3. Do not have prescription drug coverage that helps pay for your RedHill Biopharma medications

   OR

   Participate in Medicare Part D and have spent at least 3% of your total household income out of-pocket on prescription medicines during the current calendar year

The Affordable Care Act created a marketplace of Health Insurance Exchanges where uninsured individuals and families are able to purchase healthcare coverage, the cost of which may be subsidized for qualified enrollees. More information about these plans can be found at **www.healthcare.gov.**

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How to Complete this Application:

1. Review the application and gather the required documentation listed below
2. Complete pages 3, 4, 5, 6, 7, 8 and 9
3. Mail or have your doctor fax your completed application, prescription, and required documentation with a cover sheet to:

RedHill Biopharma Patient Assistance Program
P.O. Box 8308
Somerville, NJ 08876

OR

RedHill Biopharma Patient Assistance Program
Fax: 1-844-734-9961

Note: Faxed submissions not sent from your doctors office will be denied.

Please do not send your medical records with your application.

Important Information About Your Application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

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DOCUMENT CHECKLIST:

All items must be submitted together by mail or by fax to complete your application. Please keep a copy for your records.

- ☐ A completed application, signed and dated by you and your prescriber (pages 3-9)
- ☐ Proof of US citizenship (copy of birth certificate or valid US passport)
- ☐ Proof of income (please provide one of the following items to show your gross annual household income):
  - ☐ Copy of a current pay stub within the last 3 months for all working members of your household
  - ☐ Copy of last year's Federal Income Tax Return (1040)—The previous year's tax return will not be accepted after October 15th of the current year
  - ☐ Copy of Social Security income, pension, and other income statements, including interest or dividend statements
  - ☐ Copy of W-2 or 1099 Form
  - ☐ Copy of Unemployment Benefit statement
- ☐ The completed prescription on page 6 of this application
- ☐ If you are a Medicare Part D enrollee, please also include the following:
  - ☐ A copy (front and back) of your Medicare Part D card
  - ☐ Medicare Part D Prescription Drug Plan statement (Explanation of Benefits [EOB]) or a summary document from your pharmacy indicating the amount you have spent for prescriptions in the current calendar year (this total should be at least 3% of your income)

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PATIENT INFORMATION:

*Please print clearly in **blue or black** ink. Asterisks indicate required fields.*

Primary language spoken ☐ English ☐ Spanish ☐ Other: _____

☐ New Application ☐ Re-enrollment

Patient Name*: _____
First Middle Initial Last

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

Social Security #*: _____

Phone*: _____ Mobile Phone: _____ E-mail: _____

Address*: _____ City*: _____ State*: _____ Zip*: _____

☐ Patient has no current address. Medication will be shipped to alternative residential address (i.e., family member). Please note: medications cannot be shipped to Post Office (P.O.) boxes.

Ship Medication To:
☐ Patient Address ☐ Alternative Residential Address (i.e., family member)

Recipient Name*: _____

Address*: _____ City*: _____ State*: _____ Zip*: _____

As part of this PAP, RedHill may provide you notifications regarding program enrollment status and re-enrollment via phone calls. By signing below, I hereby consent to receive: autodialed and prerecorded calls to the phone number(s) provided above. I understand and agree that by signing below and entering my phone number(s), I am granting my express written consent to receive autodialed and prerecorded phone calls from RedHill Biopharma and its PAP service providers on my mobile phone and/or landline. I also understand that my consent is optional and can be freely withdrawn.

Signature*: _____ Date*: _____

INCOME*:

What is the total combined household income before taxes? (Include yourself, all adults, and all dependents)
Income Verification: The RedHill Biopharma Patient Assistance Program and its authorized third-party agents will use my date of birth and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. RedHill Biopharma and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

$ _____ Monthly OR $ _____ Yearly

Number of individuals in household: _____

*Indicates required information

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INSURANCE*:

Do you have any form of prescription drug coverage? ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Employer-furnished or commercial/private drug coverage

Please provide plan name and ID number: _____

Policy Holder Name: _____ Date of Birth*: _____ / _____ / _____
(MM/DD/YYYY)

☐ VA or Military Benefits

☐ Other Prescription Coverage _____

☐ Medicaid Prescription Drug Coverage

☐ Low Income Subsidy

☐ Medicare Part D (prescription drug coverage). Please provide payer name: _____

- If the requested medication is covered under Medicare Part D, how much have you spent on prescription medicines during the current year? $ _____

The Affordable Care Act created a marketplace of Health Insurance Exchanges where uninsured individuals and families are able to purchase healthcare coverage, the cost of which may be subsidized for qualified enrollees. More information about these plans can be found at **www.healthcare.gov.**

*Indicates required information

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This section to be completed by healthcare provider

PRESCRIPTION INFORMATION:

This form will replace all previous prescriptions that may have been sent.

Please complete prescription in its entirety.

Patient Name*: _____ Date of Birth*: _____ Phone*: _____

Address*: _____ City*: _____ State*: _____ Zip*: _____

Other Medications*: _____

Known Drug Allergies*: _____

Medication*:	Strength*:	Pkg Qty	Directions*:	Quantity*:	Refills*:
Movantik® (naloxegol) tablets	12.5 mg	30			
Movantik® (naloxegol) tablets	25 mg	30			
Aemcolo® (rifamycin) tablets (Child resistant box of 12 tablets)	194 mg	12			
Talicia® (omeprazole magnesium, amoxicillin and rifabutin) capsules (1 carton, 2 bottles of 84 capsules)	10mg, 250mg and 12.5mg	168			

Prescriber Name*: _____ Phone*: _____ Fax*: _____

Address*: _____ City*: _____ State*: _____ Zip*: _____

NPI*: _____ State License #*: _____ State of Licensure*: _____

Prescriber Signature*: _____ Date*: _____

Handwritten/valid electronic signatures accepted; no photocopies, power of attorney, or stamped signatures allowed

View full prescribing information on all RedHill products at www.redhillbio.com.

*Indicates required information

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PRESCRIBER INFORMATION:

Prescriber Name*: _____ Phone*: _____ Fax*: _____

Address*: _____ City*: _____ State*: _____ Zip*: _____

Prescriber E-mail: _____ NPI*: _____ State License #*: _____ State*: _____

Office Contact Name*: _____ Practice Name*: _____

My signature certifies that I am a licensed health care practitioner eligible under state law to prescribe, receive, and dispense the requested medication(s) listed on the attached order, shipped from RedHill, and that I am not prohibited from participating in federally funded health care programs. I am authorized and eligible in the state within which I am currently practicing to prescribe these products, and that I have my supervising Physician's approval to do so if required by law. I further certify that all information provided in the Licensed Health Care Practitioner Information section is correct.

By signing below, I (the "Prescriber") certify to the following statements:

RedHill Biopharma Patient Assistance Program policy prohibits Healthcare Professionals (HCPs) from charging patients any fee for enrollment or other activities associated solely with the patient's participation in the Patient Assistance Program ("Program").

I also understand that the applicant's acceptance into the program should not influence treatment decisions.

In accordance with the CMS Medicare Policy Manual, CMS will not reimburse you for any free product donated from RedHill Biopharma Patient Assistance Program.

The Program is limited to patients being treated on an outpatient basis.

RedHill Biopharma and its contractors and agents (together "RedHill Biopharma"), will use the information you provide to administer and improve RedHill Biopharma Patient Assistance Program (the "Program").

By signing below, you represent, covenant, and certify as follows: **(i)** My patient has provided all required written authorization(s) as required by applicable federal or state laws to release to RedHill Biopharma and the Program all patient information needed for this application, and any additional information requested by the Program, if needed, including without limitation financial and personally identifiable information in order to **(1)** identify coverage support services, and **(2)** determine eligibility and enroll patient for financial assistance; **(ii)** All of the information provided in this application is complete and accurate; **(iii)** RedHill Biopharma products are prescribed based on my medical judgment or the medical judgment of another healthcare professional in my office; **(iv)** I understand and have explained to my patient that RedHill Biopharma may modify or terminate the Program at any time without notice and that completion of this application does not guarantee enrollment in any particular part of the Program; **(v)** I understand and agree that any medications supplied by RedHill Biopharma under the Program are for use of the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, submitted to any third party payor (private or government) for reimbursement, or counted toward the patient's Medicare Part D out-of-pocket costs; **(vi)** I have not received nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Program; **(vii)** I understand that I am under no obligation to prescribe any RedHill Biopharma drugs and I have not received and will not receive any benefit from RedHill Biopharma for prescribing their drug products; and **(viii)** if I become aware of any errors in the information provided, I will promptly notify RedHill Biopharma of those errors.

The prescriber is to comply with his/her state-specific prescription requirements such as the use of a state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in delay in application and/or prescription processing. Handwritten/valid electronic signatures accepted; no photocopies, power of attorney, or stamped signatures allowed.

Prescriber Signature*: _____ Date*: _____

*Indicates required information

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PATIENT CONSENT:

I PROMISE that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare, if applicable); I will contact the Program if any of my information about my prescription drug coverage or insurance changes.

I UNDERSTAND that the Program will only use my information to decide if I qualify to participate in the Program; administer or improve the Program; communicate with insurance plans, including Medicare plans; share my information with the Centers for Medicare and Medicaid Services.

I UNDERSTAND that I may be required to apply for prescription assistance through a government assistance program to maintain eligibility in the Program.

I UNDERSTAND that I can call 1-844-734-5727 at any time to withdraw from the Program and/or cancel my permission to use my information. I can visit www.redhillus.com/privacy-policy/ to review RedHill Biopharma's Privacy Notice.

I UNDERSTAND that the Program can request more information from me at any time; RedHill Biopharma can change or stop the Program at any time or for any reason.

I UNDERSTAND that once my information has been disclosed to my doctor, federal privacy laws may no longer restrict its use or disclosure, but the Program will only use my information as described in this form.

I MAY refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program.

I GIVE the Program, and the Program administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you). This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

IF MY APPLICATION IS APPROVED:
I will notify RedHill Biopharma Patient Assistance Program of changes to my income or insurance status. I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Program. If I have Medicare Part D coverage, I will not seek to have the cost/value associated with the medication I receive through the Program counted as out-of-pocket costs for prescription drugs. If I have Medicare Part D coverage, I will inform my Part D Plan about my enrollment in the Program. RedHill Biopharma will also notify the Part D plan sponsors of your participation. I will not sell, trade, or transfer any medication I receive through the Program.

Signature of Applicant or Parent/Legally Authorized Representative*:

If patient is a minor, parent or legally authorized representative should sign here.

Relation to Patient: ☐ Patient ☐ Parent/Legally Authorized Representative of Patient

X _____ Date: _____ / _____ / _____
(MM/DD/YYYY)

*Indicates required information

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PATIENT CONSENT, CONTINUED:

HIPAA authorization:

Patient Authorization to Share Health Information.

I GIVE my doctor permission to share my protected health information with RedHill Biopharma, the Program Administrators, and their employees, agents, and contractors, and for RedHill Biopharma and the Program Administrators to use and disclose my protected health information, in order to verify my information to make sure it is true and complete; determine my eligibility for the Program; contact me by mail or phone about the Program and about other products, programs, or services that might interest me or for which I may be eligible; contact me in order to ensure that I have received the medicines sent by the Program.

I UNDERSTAND that RedHill Biopharma and the Program Administrators will only use my information to decide if I qualify to participate in the Program; administer or improve the Program; communicate with insurance plans, including Medicare plans; share my information with the Centers for Medicare and Medicaid Services.

I UNDERSTAND that I can call 1-844-734-5727 at any time to withdraw from the Program. I can visit www.redhillus.com/privacy-policy/ to review RedHill Biopharma's Privacy Notice.

I UNDERSTAND that once my protected health information has been disclosed by my doctor, federal privacy laws may no longer restrict its use or disclosure, but RedHill Biopharma and the Program will only use my information as described in this form.

I MAY refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program.

This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I may cancel my consent to use and share my personal information at any time by writing to RedHill Biopharma at the address in this application. If I withdraw my consent, I will no longer be eligible for the program and my enrollment will end. I have a right to receive a copy of this form after I have signed it.

Signature of Applicant or Parent/Legally Authorized Representative*:

If patient is a minor, parent or legally authorized representative should sign here.

Relation to Patient: ☐ Patient ☐ Parent/Legally Authorized Representative of Patient

X _____ Date: _____ / _____ / _____
(MM/DD/YYYY)

Authorized Representative Printed Name: _____

Authorized Representative Phone: (_____) _____

*Indicates required information

Questions? Call 1-844-734-5727 Monday–Friday, 9 AM to 6 PM ET or
Visit https://www.redhillbio.com/our-programs/patient-assistance-program