WD RxAccess

CONNECTING PATIENTS TO MEDICATION

The WD Rx Access program helps make it easier for patients who are prescribed Syprine® (trientine hydrochloride) or Cuprimine® (penicillamine) to have affordable access to the medication they need with:

- **Copay Assistance:** WD Rx Access provides copay assistance through a network of **Specialty Pharmacies**.
  - Patients who have commercial insurance may be eligible* to receive the prescribed product for as little as $25
- **Prescription management:** WD Rx Access representatives will connect patients to a specialty pharmacy that will coordinate fulfillment of their prescription

Patient Assistance: For patients facing financial challenges in filling their SYPRINE® or CUPRIMINE® prescription, Valeant Pharmaceuticals has a Patient Assistance Program (PAP). The PAP is subject to eligibility requirements.*
To enable WD Rx Access to determine a patient's eligibility for PAP, the following documentation must be provided:

- Completed WD Rx Access enrollment form (with patient and provider signatures) and prescription
- Documentation of household income (acceptable forms of income documentation include the patient's IRS 1040 form from the most recent tax year, W-2, or Social Security Benefit Statement)
- Proof of legal US residency (United States, Puerto Rico, or the US Virgin Islands)

ENROLLMENT FORM REQUIREMENTS

All services offered by WD Rx Access **require a completed enrollment form** containing both patient and prescribing healthcare provider signatures. Completed enrollment forms can be mailed or faxed to:

WD Rx Access
PO Box 220667, Charlotte, NC 28222-0667
Fax: (855) 735-4624

After reviewing your enrollment form, WD Rx Access will notify you and your physician by mail of your eligibility determination. If you have any questions about the program or application process, please call **(888) 607-7267**. WD Rx Access representatives are available Monday through Friday, 8:00 AM – 6:00 PM, Eastern Time.

Please see Boxed Warning for Cuprimine® below regarding the risk of toxicity, and accompanying full Prescribing Information.

WARNING FOR CUPRIMINE®

Physicians planning to use penicillamine should thoroughly familiarize themselves with its toxicity, special dosage considerations, and therapeutic benefits. Penicillamine should never be used casually. Each patient should remain constantly under the close supervision of the physician. Patients should be warned to report promptly any symptoms suggesting toxicity.

Please see accompanying full Prescribing Information for Syprine® Capsules.

*This offer is not valid for any person eligible for reimbursement of prescriptions, in whole or in part, by any federal, state, or other governmental programs, including, but not limited to, Medicare (including Medicare Advantage and Part A, B, and D plans), Medicaid, TRICARE, Veterans Administration or Department of Defense health coverage, CHAMPUS, the Puerto Rico Government Health Insurance Plan or any other federal or state health care programs. These patients may qualify for alternative financial assistance. These offers are only good for use with Syprine® and Cuprimine®. No other purchase necessary. These offers are not health insurance. These offers are not transferable. These offers are not valid with other offers. These offers have no cash value. The patient understands and agrees to comply with the terms and conditions of these offers. Program term eligibility expires December 31, 2018. Valeant Pharmaceuticals reserves the right to rescind, revoke, terminate, or amend these offers at any time, with or without notice. For more information, call a WD Rx Access representative at 888-607-7267.

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ATTENTION: THE PATIENT INFORMATION SECTION MUST BE COMPLETED PRIOR TO THE HEALTHCARE PROVIDER FILLING OUT THE PROVIDER CERTIFICATION SECTION

Return this completed application with a valid prescription to:
WD Rx Access, PO Box 220667, Charlotte, NC 28222-0667; or by fax: (855) 735-4624

PRESCRIPTION INFORMATION

Check the product for which you are requesting assistance:

☐ Syprine® (trientine hydrochloride)
Sig. _____

☐ Cuprimine® (penicillamine)
Sig. _____

Check the specialty pharmacy you would like to fill your prescription:

☐ CVS Specialty ☐ AllianceRx Walgreens Prime ☐ Accredo Health Group, Inc. ☐ US Bioservices

PATIENT INFORMATION

Patient Name: _____ SS #: _____ DOB: _____

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

Day Phone #: _____ Evening Phone #: _____ Email Address: _____

☐ Yes, I authorize messages to be left on my voicemail regarding the information I've provided and the status of my prescription.

DELIVERY INFORMATION (Please indicate shipping address if different from above)

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

Delivery Contact Name: _____ Contact Phone: _____

INSURANCE INFORMATION (Complete or include demographic sheet)

Primary Insurance (Include Medicare information, if applicable)

Insurance Company Name: _____ Policy ID #: _____ Group #: _____

Phone #: _____ Subscriber Name: _____ Date of Birth: _____

Prescription Card #: _____ Carrier: _____ Rx Card Phone #: _____

Secondary Insurance (Include Medicare information, if applicable)

Insurance Company Name: _____ Policy ID #: _____ Group #: _____

Phone #: _____ Subscriber Name: _____ Date of Birth: _____

Prescription Card #: _____ Carrier: _____ Rx Card Phone #: _____

FINANCIAL INFORMATION (Patient assistance only)

Current gross annual household income: $_____ Number of members in household: _____

Income Verification Source: ☐ 1040 ☐ W-2 ☐ Social Security Benefit Statement

I, _____ (patient's name), verify that the information provided in this application is complete and accurate. I do not have the financial resources to pay for product. I agree that if I am eligible and receive any free product, approval is not valid for prescriptions reimbursed under Medicaid, a Medicare drug benefit plan, or any other federal or state programs (such as medical assistance programs). Program approval is not valid for Massachusetts residents or where otherwise prohibited by law. The patient is responsible for reporting receipt of this offer to any health insurer, health plan, or third-party payer as may be required. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that Valeant reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

PATIENT AUTHORIZATION (Required)

I authorize my healthcare providers and health plans to disclose my protected health information ("PHI") to Valeant and its agents and contractors ("Valeant") to: (1) establish my eligibility for benefits through WD Rx Access; (2) communicate with my healthcare providers and me about my medical care; and (3) provide support services including facilitating the provision of product to me. I understand that once my PHI has been disclosed to Valeant, federal privacy laws may no longer restrict its further disclosure. Valeant agrees to use and disclose this information only for the above purposes and as permitted by law.

I further understand I may refuse to sign this authorization and that my healthcare providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I agree to immediately notify WD Rx Access of any change in my insurance status and understand that such changes may render me no longer eligible for assistance through WD Rx Access. I may cancel this authorization by notifying Valeant in writing and submitting the cancellation by fax or by mail to: (855) 735-4624 or PO Box 220667, Charlotte, NC 28222-0667. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me or as dictated by applicable state law.

Patient Signature: _____ Date: _____

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PROVIDER INFORMATION

Provider Name: _____ NPI #: _____ DEA #: _____

Tax ID #/Provider ID #: _____ State License #: _____

Site/Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Contact Name: _____

CLINICAL INFORMATION (Please attach valid prescription to form)

Diagnosis Code(s): _____

PROVIDER CERTIFICATION (Required)

I attest that the information provided is current, and accurate to the best of my knowledge. I certify that product is medically necessary for this patient and I will be supervising the patient's treatments. I have obtained from my patient all required authorizations for the release to Valeant and its agents and representatives of my patient's identification and insurance information. I understand that any information provided is for the sole use of Valeant and its agents and representatives to verify my patient's insurance coverage and to assess, if applicable, patient's eligibility for participation in WD Rx Access and to otherwise administer WD Rx Access. I understand that application to WD Rx Access does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the patient assistance program ("PAP"), and I agree to immediately notify WD Rx Access if I become aware of such a change in status. I certify that I will not bill for or accept payment from patients (or any third party), in whole or in part, for product obtained through the PAP. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for product supplied through the PAP, I will immediately notify a WD Rx Access representative, and I understand that in such event Valeant will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe product and that I have not received nor will I receive any benefit from Valeant or its agents or representatives for prescribing product.

Check box to confirm your agreement to receiving faxes from WD Rx Access ☐

Provider Signature: _____ **Date:** _____

Supervising Physician: _____ **Date:** _____

No stamps. Physician signature required.
NY prescriptions must be submitted on NY State Rx form.

This offer is not valid for any person eligible for reimbursement of prescriptions, in whole or in part, by any federal, state, or other governmental programs, including, but not limited to, Medicare (including Medicare Advantage and Part A, B, and D plans), Medicaid, TRICARE, Veterans Administration or Department of Defense health coverage, CHAMPUS, the Puerto Rico Government Health Insurance Plan or any other federal or state health care programs. These patients may qualify for alternative financial assistance. These offers are only good for use with Syprine® and Cuprimine®. No other purchase necessary. These offers are not health insurance. These offers are not transferable. These offers are not valid with other offers. These offers have no cash value. The patient understands and agrees to comply with the terms and conditions of these offers. Program term eligibility expires December 31, 2018. Valeant Pharmaceuticals reserves the right to rescind, revoke, terminate, or amend these offers at any time, with or without notice. For more information, call a WD Rx Access representative at 888-607-7267.

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