



**ENROLLMENT APPLICATION**

All fields required  
Mail completed application to:

Validus Pharmaceuticals LLC  
119 Cherry Hill RD, Suite 310  
Parsippany, NJ 07054

**Patient Assistance Program**

**Program Eligibility:**

- Patient must be a legal resident of the United States.
- Patient cannot be covered or eligible for any government prescription programs such as Medicaid, Medicare Part D, Veteran's Administration, or any State or local programs, either directly or indirectly (through other household members).
- Patient cannot be covered by any private prescription coverage such as an HMO or PPO plan, either directly or indirectly (through other household members).
- Patients must meet specific program criteria; **not everyone who applies will qualify for enrollment. Proof of household income is required with original application and annually. (Household income is defined as all sources listed Section B, Eligibility, Page 1 of Enrollment Form).**
- Household income must not exceed 200% of the 2011 Federal Poverty Level (FPL) as listed in the chart below:

Family Size	200% of 2011 FPL
1	\$21,780
2	\$29,420
3	\$37,060
4	\$44,700
5	\$52,340
6	\$59,980
7	\$67,620
8	\$75,260

**Medications Available  
Through The Patient  
Assistance Program Are  
Subject To Change At Any  
Time**

**Initial Enrollment Instructions:**

**Patient Instructions**

- Patient "Information & Eligibility" section (page 1) and Patient Assistance Program Authorization Form (page 3) must be completed and must include the patient's original signatures.

**Practitioner Instructions**

- "Practitioner" section (page 2 of form) must be completed with original signature of authorized physician.
- Please attach an original prescription of the medication, written for a **three-month supply** to the application. **NO AUTOMATIC REFILLS.**
- Attach copy of the patient's **most recent federal tax return** and all supporting documentation (W-2 / 1099, social security statement, disability statement, pension, unemployment, etc.) **Updated proof of household income is required annually.**
- If the patient does not file taxes, submit a form 4506-T to the IRS as Verification of Non-Filing. The letter of response from IRS should be forwarded to Validus upon receipt.
- **Mail original application, original three-month prescription and all documentation for proof of income to the address listed above.**
- Both the patient and practitioner will be advised in writing of any denied requests.
- Incomplete applications will be returned to the practitioner for completion.

**Continuing Enrollment Instructions**

- Patient "Information & Eligibility" section (page 1 of form) must be completed and must include original signatures.
- "Practitioner" section (page 2 of form) must be completed with original signature of authorized physician.
- Attach an original prescription of the medication, written for a **three-month supply** to the application. **NO REFILLS.**
- **Mail original application and original prescription to the address listed above.**
- **Proof of household income must be verified annually.**
- Both the patient and practitioner will be advised in writing of any denied requests.
- Incomplete applications will be returned to the practitioner for completion.

**Patient Assistance Program – Enrollment Form  
Section 1: Patient Information**

Patient's Name: \_\_\_\_\_  
(First) (Last) (M.I.)

SS# \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status \_\_\_\_\_

Phone \_\_\_\_\_

**IF ALL INFORMATION IS  
NOT CLEAR AND  
COMPLETE, THIS FORM  
WILL BE RETURNED**

**Eligibility**

A. Is the patient a legal U.S. resident?  Yes  No

B. List all Sources of Income, **Gross Monthly Amounts:**

Salary/Wages	\$ _____	Social Security	\$ _____
Social Security Disability	\$ _____	Pension/Retirement	\$ _____
Child Support/Alimony	\$ _____	Unemployment/Workers Comp	\$ _____
Investment Income	\$ _____		

C. Is the patient directly or indirectly (through other household members) covered or eligible in any of the following:

<b>Prescription Drug Coverage</b>			
Prescription Drug Coverage: Private/Commercial Insurance	Yes	<input type="text"/>	No <input type="text"/>
Medicaid Drug Coverage	Yes	<input type="text"/>	No <input type="text"/>
Medicare Drug Coverage/ Medicare Part D	Yes	<input type="text"/>	No <input type="text"/>
State Elderly Drug Assistance	Yes	<input type="text"/>	No <input type="text"/>

D. Total **ANNUAL** household income; including all sources listed above in section B, must **NOT** exceed **200% of Federal Poverty Level** (see chart under Program Eligibility). \$ \_\_\_\_\_

E. Number of persons residing in household (including patient). \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (must be original – no photocopies)

\_\_\_\_\_  
Date

**PATIENT DECLARATION – PLEASE READ AND SIGN**

I verify that the information provided in this application is complete and accurate. I authorize Validus Pharmaceuticals LLC to use this information to assess my eligibility for participation in the Patient Assistance Program ("Program"), including the audit of my medical records and/or by contacting my health care provider, my insurance company or me directly to confirm my eligibility or receipt of drug or matters related to such program. I understand that this assistance is temporary and that this Program may be discontinued or changed at any time. I understand that Validus Pharmaceuticals LLC will use my personal information in connection with the operation of the Program and issues related to the Program. I certify that I do not have the ability to pay for my medication, earn less than 200% of the current HHS Poverty Guidelines, am a U.S. resident, and that I have no government or private insurance to pay for my medication. I also certify that I do not have other sufficient financial resources or assets to pay for the medication requested or that paying for the medication from my own resources or assets would cause me severe financial hardship. I understand that I am expected to seek any available State or government assistance before applying or reapplying to the Validus Pharmaceuticals Patient Assistance program. I agree not to submit an insurance claim or any other claim for payment to any third party payor (private or government) for the prescription product. I agree not to resell, offer for sale, trade or barter, or return for credit the prescription product and that it will be utilized solely for my personal use. I have read and agree to all terms of the Patient Declaration on this application. I attest the information I have provide is correct and complete.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

IF ALL INFORMATION IS NOT CLEAR AND COMPLETE, THIS FORM WILL BE RETURNED

Section 2: Practitioner Information

Practitioner's Name: \_\_\_\_\_  
(First) (Last) (M. I.)

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

Address: \_\_\_\_\_

State License # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email : \_\_\_\_\_

I represent that the information contained in this application is complete and accurate to the best of my knowledge. I certify that the use of the indicated medication is medically necessary and I will be evaluating the patient's treatment. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare Part D or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the prescription product or for professional services rendered in association with the prescription of the product. I understand that Validus Pharmaceuticals LLC reserves the right to modify or terminate this program at any time or to refuse to distribute the medication under this program to any patient or physician. Validus Pharmaceuticals LLC also reserves the right to modify the financial eligibility criteria at any time. My signature certifies that goods received from Validus Pharmaceuticals LLC are for the use of the above named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. Validus Pharmaceuticals LLC reserves the right to recall the product when necessary.

Signature of Licensed practitioner (Must be original - No stamped signatures or photocopies) \_\_\_\_\_ Date \_\_\_\_\_

All information in this application will be kept confidential to the patient as permitted by law and regulation.

**Patient Assistance Program Authorization Form**

This Patient Assistance Program Authorization Form authorizes your health care provider to disclose your health and medical information to Validus Pharmaceuticals LLC and their respective employees, representatives and agents or its suppliers (collectively, "Validus") in connection with your application to the Patient Assistance Program ("PAP") as required by the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPPA").

**Authorization**

I, \_\_\_\_\_ [First, Middle and Last Name], hereby authorize \_\_\_\_\_ [Name of Physician or Medical Group] ("Health Care Provider") to disclose my individually identifiable health and medical information described below to Validus solely for the authorized purpose described in this authorization form.

**Description of Health and Medical Information That May Be Disclosed**

My Health Care Provider may disclose individually identifiable health and other information that supports my application to the PAP and may include my name, address, date of birth, social security number, financial information, medical records and the specialty of my Health Care Provider.

**Authorized Purposes**

The authorized purposes are: (1) to permit Validus to evaluate my eligibility for participation in the PAP, and (2) if Validus, in its sole discretion, approves my request to participate, for Validus's administration of my participation in the PAP.

**Expiration of Authorization**

My authorization shall expire (1) when Validus does not approve my application for participation in the PAP, or (2) at the conclusion of my participation in the PAP, whichever is earlier.

**Acknowledgements**

- (1) I understand that Validus is not an entity covered by HIPPA and related federal privacy regulations and that my medical and health information may be subject to disclosure by Validus and no longer protected by such federal privacy regulations. I further understand and agree that Validus may retain my medical and health information as disclosed to Validus by my Health Care Provider under this authorization after this authorization expires for purposes related to the administration of the PAP.
- (2) I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my Health Care Provider; or to seek payment or my eligibility for benefits. However, I understand that I may not participate in the PAP if I refuse to sign this authorization form.
- (3) I understand that I may revoke my authorization at any time by providing a written notice of same to my Health Care Provider that refers to (or with a copy of) this authorization form, or as set forth in my Health Care Provider's Notice of Privacy Practices (if any). However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my Health Care Provider to Validus in reliance on this authorization. This authorization will expire at the end of my participation in the PAP.

Signed	Dated
Patient's Name	
Name of Personal Representative (if applicable)	Relationship to Patient

**Health Care Provider Must Give Patient and/or Patient's Representative A Signed Copy**

Health Care Provider has verified Patient Representative's authority to act on Patient's behalf \_\_\_\_\_ (initial)