Waylis Patient Access & Affordability

Patient Assistance Program

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PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application must be completed, signed, and dated by both the Healthcare Professional and Patient.
- Patient must submit one of the following pieces of Proof of US Residency documentation:
  - I. A valid driver's License or state-issued ID card
  - II. Passport
  - III. Veteran or active military ID card
  - IV. Social Security benefit letter
  - V. Active Medicaid coverage letter obtained from Medicaid plan or physician's Medicaid eligibility portal

- Patient must submit one of the following pieces of Proof of Income documentation:
  - I. Federal Income Tax (form 1040 or 1040EZ) with appropriate schedule (C and/or F)
  - II. Federal Income Tax Form 1099
  - III. Yearly benefits statement (SSA, 1099, etc.)
  - IV. Award letter
  - V. Bank statements showing automatic deposit for the current calendar year
  - VI. Minimum of 3 most current pay stubs

ELIGIBILITY & REQUIREMENTS

- Patient cannot have prescription coverage through any private insurance.
- Patient's annual household income must be at or below 500% of the current Federal Poverty Level.
- Patient must be a resident of the US or US territories.

GENERAL PROGRAM INFORMATION

- The requested medication will ship to the Patient's address.
- Before the patient is due for a refill, the Healthcare Professional and the Patient must sign and submit a new application. For assistance with program enrollment, please contact the WAYLIS Patient Assistance program at:

(888) 218-8897

PATIENT CHECKLIST

✓ Patient or Patient Caregiver provided complete information as requested in STEP 1 and Step 2. YES NO

✓ Patient or Patient Caregiver has and will supply required proof of income documentation. YES NO

➢ If "NO" to proof of income, please contact the WAYLIS Patient Assistance Support program at:

(888) 218-8897

HEALTHCARE PROFESSIONAL CHECKLIST

- Healthcare Professional provided complete information as requested in STEP 3 and STEP 4. **YES** **NO**

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Phone: (888) 218-8897 ■ Fax: (844) 470-1931

STEP 1 – PATIENT INFORMATION – TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

Patient First Name: MI: Patient Last Name:

Address: City: State: Zip:

Date of Birth: (MM/DD/YYYY) Gender: Male Female Patient Weight: lbs kg (circle one)

Primary Phone: Email: Marital Status: S M W D

Are you a U.S. Resident? Y N Are you a Veteran? Y N Are you Disabled? Y N

Gross Annual Household Income: Number of Persons in Household:

Contact Name: (if other than patient) Relationship to Patient:

Proof of Income Documentation is required for this program. Please select the documents you intend to submit:

Federal Tax Return Social Security Income Bank Statements/Paycheck Stubs (minimum of 3)

Medicaid Coverage Letter Other:

STEP 2 – PATIENT INSURANCE INFORMATION – TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

What type of insurance coverage do you have? ***NO INSURANCE COVERAGE?*** (Circle Here)

Medicare A/B Medicare Part D Medicare Advantage

Medicaid Employer Other

For each insurance policy you have, please attach a copy of both the front and back of your insurance card and fill in the following:

Primary Insurance Name: Secondary Insurance Name:

Phone Number: Phone Number:

Policy ID: Policy ID:

Group Number: Group Number:

I certify that the information in Sections 1 and 2 are complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize Waylis Therapeutics Inc. to obtain and disclose information from physicians, insurance companies and others as necessary to verify the information provided on this application.

Patient Signature: Date: / /

STEP 3 – PROFESSIONAL INFORMATION – TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR OFFICE

Physician First Name: Physician Last Name: Prof. Designation:

Address: City: State: Zip:

DEA Number: (if applicable) NPI Number:

Office Telephone: Office Fax:

Office Contact Name: Contact Phone: Ext:

Office Contact Fax: Contact Email:

STEP 4 – PRESCRIPTION INFORMATION – THIS IS THE PRESCRIPTION; NO ADDITIONAL PRESCRIPTION IS NEEDED

MEDICATION NAME	RX DIRECTIONS	QUANTITY	REFILLS
Leukeran 2mg Tablet			0 1 2 3 4 5
Myleran 2mg Tablet			0 1 2 3 4 5
Tabloid 40mg Tablet			0 1 2 3 4 5
Eulexin 125mg Capsule			0 1 2 3 4 5

I certify that the information in Section 3 is complete and accurate to the best of my knowledge. I understand that additional information may be requested to process this application, but that all information will be kept confidential, except otherwise required by law. I hereby authorize Waylis Therapeutics Inc. to obtain and disclose information from insurance companies and others as necessary to verify the information provided on this application.

Healthcare Professional Signature: Date: / /