Waylis Patient Access & Affordability

Patient Assistance Program

PLEASE DO NOT FAX THIS PAGE BACK

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:
  1. A valid driver's License or state issued ID card
  2. Passport
  3. Veteran or active military ID card
  4. Social security benefit letter

- Patient must submit one of the following pieces of Proof of Income documentation:
  1. Active Medicaid coverage letter obtained from Medicaid plan or physician's Medicaid eligibility portal.
  2. Federal Income Tax (form 1040 or 1040EZ) with appropriate schedule (C and/or F)
  3. Federal Income Tax Form 1099
  4. Yearly benefits statement (SSA, 1099, etc.)
  5. Bank statements showing automatic deposit for the current calendar year
  6. Minimum of 3 most current pay stubs

ELIGIBILITY & REQUIREMENTS

- The medication cannot be covered by a Commercial or Government funded insurance plan.
- 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 can be shipped to the patient's home or prescriber's office upon request.
- Patient Assistance Program (PAP) enrollment is only available to patients who meet program eligibility requirements AND their private or government funded insurance plan doesn't cover the medication at issue.
- Before the patient is due for yearly renewal, 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
✓	Patient or Patient Caregiver has and will supply required proof of US residency documentation.	☐ YES ☐ NO
✓	By signing the application, I certify that I have read and agreed to the terms of the patient declaration on page 5.	☐ 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
✓	By signing the application, I certify that I have read and agree to the terms of the Physician Authorization on page 5.	☐ YES ☐ NO

WAYLIS PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

PATIENT DECLARATION AND AUTHORIZATION TO SHARE HEALTH INFORMATION

DO NOT SUBMIT THIS PAGE – IT IS FOR PATIENT AND PROVIDER RECORDS ONLY

Please read, sign and date on Page 5, Patient Section (STEP 2)

I certify that:

- The information on this form is correct and complete including all copies of documents proving my income and, to the best of my knowledge, I meet the eligibility requirements for patient assistance and have complied with all requirements for the submission of the application.
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from the Waylis Patient Access & Affordability Program and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application.
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider, or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to Waylis to ensure all information is accurate and true. No other third party has assisted with the completion of this application.
- The product(s) provided under this patient assistance program will not be sold or traded.
- I will notify the Waylis Access & Affordability Patient Assistance Program within thirty (30) days if there is any change in my income or health insurance coverage. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D.
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Waylis Access & Affordability Patient Assistance Program to any person or entity.

I fully understand that:

ProMod Rx is an independent pharmacy that manages the Waylis Access & Affordability Patient Assistance Program to provide assistance in the form of medically necessary, free medications to financially needy patients who have no other way to access such drugs; ProMod Rx will rely on the information provided in this application to determine whether I am eligible for assistance; the knowing submission of an application that includes false information in order to obtain assistance could constitute fraud; and Waylis has the right to report fraud to government authorities or otherwise take legal action to protect its assistance assets from fraudulent activity.

I authorize the following communications:

- Waylis or its agents contacting insurers, other potential funding sources – including the Centers for Medicare & Medicaid Services, state Medicaid programs or other charities, social workers, or patient advocacy organizations on my behalf in order to confirm that I either do not have active insurance coverage or my insurance plan does not cover the prescribed medication and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.
- ProMod Rx or its agents contacting me to request my feedback on the quality and efficacy of the Waylis Access & Affordability PAP Program.
- The company who made my medicine or its agents contacting me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.

WAYLIS PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

PATIENT DECLARATION AND AUTHORIZATION TO SHARE HEALTH INFORMATION *(cont'd)*

I understand that Waylis PAP and third parties associated with administrating the Program on behalf of Waylis (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family's income, including verification of my income, or my lack of insurance coverage and that the information may be requested from me, others acting on my behalf or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program.

Patient Authorization to Share Health Information: By signing on Page 5, I hereby authorize:

- My doctor(s), pharmacy, and other healthcare providers ("Entities") to disclose to and share with Waylis, the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees ("Waylis Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record.
- The Waylis Recipients to access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application; verifying the information provided in this Application; assisting in the identification of or determining eligibility under the Program and other patient assistance resources; assessing eligibility for no or low cost insurance options, such as Medicaid; coordinating the dispensing and delivery of medication; assessing and communicating the availability of other third party patient assistance resources, including programs offered by the company that manufacturers my medicine or patient organizations that provide a range of patient assistance; auditing for compliance with Program requirements; replace with: conducting the additional services described above; running the Program; and undertaking other internal business purposes.

In addition, by signing on Page 5, I understand and agree that:

I may refuse to sign the form on Page 5. This authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program. I understand that my doctor(s), pharmacy and other healthcare providers, may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.

- Health information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA).
- The information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.
- I may withdraw my authorization at any time by mailing a written withdrawal to Waylis Therapeutics LLC at 2131 Felver Court Suite B, Rahway, NJ 07065; however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- This authorization will last until I am no longer participating in the Program or sooner as limited by applicable federal and state laws.

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WAYLIS PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

PHYSICIAN AUTHORIZATION: WAYLIS ACCESS & AFFORDABILITY PAP POLICY AND TERMS & CONDITIONS AGREEMENT

Please read, sign and date on Page 5, Professional Information (STEP 4)

The Waylis Access & Affordability PAP 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").

- Waylis requests that HCPs not charge the patient for those professional services associated with administration of product provided by Waylis PAP Program if those services are not covered by the patient's health insurer.
- No claim may be made to any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program.
- The product(s) provided under the Program may not be sold or traded and may not be returned for credit.
- The Waylis PAP Program is limited to patients being treated on an outpatient basis.
- Waylis and the vendors associated with administrating the Program (collectively, the "Program Administrators") reserve the right to request additional information if needed and to change or terminate the Program at any time, without notice.
- Waylis and the Program Administrators reserve the right to refuse to distribute the medications under this program to any patient or facility at any time, without notice. Indicate your agreement to the terms of the JJPAF Program participation by signing in the "HCP Authorization" section(s) for the product(s) you have prescribed.

Your signature is required to confirm to Waylis:

- There is a valid medical need for this patient's prescription.
- I authorize Waylis or its affiliated companies or subcontractors to transmit the patient's prescription by any means under applicable law to a dispensing pharmacy on behalf of the patient.
- I authorize ProMod Rx to use my provider information, including National Provider ID #, to determine a patient's eligibility in the Program.
- That to the best of my knowledge, this patient either, does not have prescription drug insurance coverage OR their insurance plan does not cover the prescribed medication.
- I am not prohibited from participating in federally funded or state healthcare programs nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
- That the medication(s) provided to me by the Program will not be provided or dispensed to any other person.
- I have a signed copy on file of my patient's current and completed patient authorization to share health information in accordance with HIPAA, or any other authorization or consent required by law, so that I may share patient health information with the Program, including the Waylis Recipients.
- I understand that the information provided in this application may be subject to random audits and verification and that, during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests. I further understand that Waylis may suspend the provision of free product to my patients during or as the result of such audits.

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Waylis Patient Access & Affordability

Patient Assistance Program

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 ☐

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 ACTIVE INSURANCE COVERAGE?*** ☐ *(Check Here)*

☐ Medicare A/B ☐ Medicare Part D ☐ Medicare Advantage

☐ Medicaid ☐ Employer/Commercial Plan ☐ 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 above, as well as on the attached patient declaration page 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: NPI Number:

Office Address: City: State: Zip:

DEA Number: (if applicable) Office Phone #: Office Fax #:

Office Contact (OC) Name: OC Phone #: (____)_____ Ext#: _____ Email:

Medication Shipping Preference (Circle One): **PATIENT HOME ☐ **MD OFFICE** ☐ **OTHER** ☐

** MEDICATION SHIPPING ADDRESS:

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 STEPS 3 & 4 on this page, as well as the attached Physician Authorization page 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.

Physician Signature: Date: / /