BAUSCH Health | Patient Assistance Program Application

The Bausch Health Patient Assistance Program (PAP) provides free medications to eligible patients with limited or no insurance coverage and/or who demonstrate qualifying financial need. All applications are reviewed on a case-by-case basis and there is no cost to apply.

You may be eligible if you:

- Are a legal United States resident
- Have a valid prescription from a licensed U.S. healthcare professional for a product made available through the Bausch Health PAP
- Do not reside in a hospital, nursing home, correctional facility, or court-appointed program or facility
- Do not have insurance coverage for the prescribed Bausch Health product
- Are being treated as an outpatient
- Meet the pre-defined eligibility requirements and total annual household income requirements

For full eligibility requirements, and currently available products, please visit BauschHealthPAP.com

APPLICATION INSTRUCTIONS

- Fill out all required fields completely on the **Patient Application (Page 1)**
- Gather and send in copies of all required documents with your application including:
  - Copies of the front and back of all insurance cards
  - Copies of your income documentation:
    - First 2 pages of your latest tax return (e.g. Form 1040)
    - If you do not file a tax return, provide copies of all sources of your household income. This may include your latest Social Security statement, disability benefits statement, unemployment benefits, pension statements, and any other household income documents.
    - If you do not have any income documentation, please call Bausch Health PAP at 833-862-8727
  - Ask your Prescriber to fill out all required fields completely and sign the **Prescriber Application (Page 3)**
- Carefully review all **Patient Authorizations (Page 2)**; you need to authorize Bausch Health PAP to determine if you are eligible for the program
- **Sign your completed application**
- Ask your Healthcare Provider to fill out all required fields completely and sign the **Prescriber Application Authorization (Page 4)**
- Fax or mail your completed and signed Patient Application with all of your required documents along with the completed Prescriber Application to Bausch Health PAP

Note: Bausch Health Patient Assistance Program benefits, rules, and product availability are subject to change at any time without prior notification.

You are encouraged to report negative side effects of prescription drugs to FDA at www.fda.gov/Safety/MedWatch, or call 1-800-FDA-1088.

Keep this page for your records.


BAUSCH HEALTH PATIENT ASSISTANCE PROGRAM
P.O. Box 991624 Louisville, KY 40269


PHONE:
833-862-8727


FAX:
844-705-0160

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BAUSCH Health | Patient Assistance Program Application

Patient Application (Page 1)

*REQUIRED: These fields must be completed

Please check one of the following: ☐ New Patient ☐ Re-enrolling Patient

Section 1: PATIENT INFORMATION

*First Name _____ *Last Name _____

*Patient Home/Shipping Address (No PO Box) _____ Email _____

*City _____ *State _____ *Zip _____ Mobile Phone _____ Home Phone _____

*SSN: ___ – ___ – ___ *Date of Birth (mm/dd/yyyy): ___ / ___ / ___

*Gender: ☐ Male ☐ Female *Legal U.S. Resident: ☐ Yes ☐ No

Section 2: INCOME INFORMATION

You will need to send in copies of the first 2 pages of your latest tax return.

If you do not file a tax return, provide copies of your latest documentation of **all household income**. This may include your latest Social Security statement, disability benefits statement, unemployment benefits, pension statements, and any other source of income your household receives.

*Annual Gross Household Income: $ _____ *Household Size: _____

Section 3: INSURANCE INFORMATION

You will need to send in copies of the front and back of **all** insurance cards with your application. This includes your primary, secondary, and prescription coverage cards.

Please check all that apply:

☐ I am **uninsured**. I **do not** have health insurance or prescription drug coverage

☐ I have **Private Insurance** (such as HMO or PPO on my own or through my employer)

☐ I have **Medicaid** coverage ONLY

☐ I have **Medicare** and/or other government coverage (e.g. Medicaid, VA, TRICARE, DOD, etc.)
If you received a denial letter for Low Income Subsidy, please attach a copy with your application

Section 4: PATIENT SIGNATURE

By signing, I am confirming that I have read, understood, and agree to the Patient Authorization and Release as written on Patient Application Page 2 (the following page).

Applicant's Signature: **Date (mm/dd/yyyy):**

SIGN _____ DATE _____

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Patient Authorizations & Release Information (Page 2)

By signing the patient application page:

a) I certify that the information provided in this application, including all copies of documentation, if applicable, is complete and accurate, and that I am authorized to sign this application.
b) I certify that I do not reside in a hospital, nursing home, correctional facility, or court-appointed program or facility.
c) I understand that benefits under the Bausch Health PAP will terminate if the program determines that any of the information supplied was NOT truthful or accurate.
d) I understand that completing this application does not ensure that I will qualify for the Bausch Health PAP.
e) I have read, understand, and agree with all of the authorizations below.

Patient Authorization For Use & Disclosure Of Personal Health Information

I authorize my health care providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Personal Information") to Bausch Health Companies Inc., its affiliates and service providers ("Bausch Health") and the Bausch Health PAP program, and its service providers ("BH PAP") so they can provide the following support services (the "Services"):

1. Help coordinate insurance coverage for, access to, and receipt of my medication.
2. Communicate with me about possible assistance through the BH PAP, and, if I am enrolled, administer my participation in the program.
3. Communicate with me about my medication, including refill reminders and other related product and program information.
4. Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Bausch Health and BH PAP may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other health care providers may receive payment from Bausch Health and BH PAP for providing certain Services, such as medication or refill reminders, based on my enrollment or participation.

Once I authorize disclosure of my Personal Information, I understand it may no longer be protected by federal health privacy laws and applicable state laws.

I understand that I have a right to receive a copy of my information and I can cancel this Authorization at any time by calling (833) 862-8727 or by writing to Bausch Health PATIENT ASSISTANCE PROGRAM, P.O. Box 991624, Louisville, KY 40269. If I cancel this authorization, I may no longer qualify for Services from Bausch Health or BH PAP, but it will not change my Provider's treatment or my insurance benefits. I understand that if a Provider discloses my Personal Information to Bausch Health or BH PAP on an authorized, ongoing basis, my cancellation will take effect for that Provider as soon as they receive notice of my cancellation. Cancellation will not affect any uses or disclosures made prior to receipt of such notice.

Authorization For Electronic Income Verification

I authorize BH PAP and its service providers to obtain a consumer report and/or information from a consumer reporting agency to verify my income, identity, and financial eligibility for the Program.

- I provide my written authorization under the Fair Credit Reporting Act (FCRA) for this purpose.
- I understand that my consent is required to proceed with financial screening and that additional documentation or eligibility requirements may apply. This inquiry is for eligibility determination purposes only and is not a request for credit.

Attestation For Patients With Government Insurance

I certify and attest that I am not currently receiving benefits or coverage for the product(s) noted on the prescriber section of the application (page 3) from Medicaid, Medicare, or any other federal, state, or local government funded health care program, or from any public or private insurance or assistance program. I acknowledge and agree that I shall not report or apply the value of any product provided to me under the Bausch Health PAP toward any insurance deductible and that if I am enrolled in Medicare Part D, I will not count such product as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit.

I further agree that I will not seek reimbursement from or submit claims to any insurance provider or health plan, including Medicare Parts B or D, or Medicaid, for the costs of any product provided at no charge by the Bausch Health PAP. For the duration of my eligibility, I agree that the products I receive through the Bausch Health PAP will be used solely for my personal use and may be dispensed through Bausch Health PAP's designated pharmacy or fulfillment providers.

Attestation For Patients With Any Kind Of Insurance

I agree to promptly contact Bausch Health if there is any change to my prescription drug coverage or insurance status, or eligibility information. I understand that Bausch Health and any third party engaged to assist in the administration of the BH PAP has the right to verify my eligibility, including the right to audit any information provided by me or my physician. I understand that the parties disclosing or receiving my data pursuant to this authorization may receive compensation from Bausch Health for services related to the administration of the BH PAP.

Attestation For Email And Communication

I also understand that Bausch Health has the right to contact me directly by phone, mail, or email, if my email address was supplied on page 2, for the purposes related to the BH PAP administration, including confirmation of product delivery. I understand that Bausch Health reserves the right to modify, suspend, or discontinue the program or terminate any benefits I receive at any time, and without notice, subject to appliable law. I authorize Bausch Health to forward the prescription associated with this application to a dispensing pharmacy on my behalf. I understand that the Bausch Health PAP is not insurance and does not provide insurance coverage or benefits.

Bausch Health does not provide product to individuals having insurance associated with any type of alternative funding program that conditions, restricts, or adjusts coverage based on the application to BH PAP or any other free goods program.

This Authorization will automatically expire upon the earliest of (i) the conclusion of my participation in the BH PAP, (ii) my discontinuation of eligibility in the BH PAP, or (iii) the termination of the BH PAP.

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BAUSCH Health | Patient Assistance Program Application

Prescriber Application (Page 3)

*REQUIRED: These fields must be completed

Section 1: PRESCRIBER INFORMATION

*Prescriber's First Name: _____ M.I. _____ *Prescriber's Last Name: _____

*Prescriber NPI#: _____ *State License#: _____ DEA#: _____
Required for controlled substance products

*Name of Facility/Site/Health System: _____

*Street Address: _____ *City _____ *State: _____ *Zip: ___ / ___ / ___ / ___ / ___

*Office Phone: _____ *Ext: _____ *Secure Fax: _____

*Professional Designation: _____ Office Contact Name: _____

Email address: _____ ☐ Shipment defaults to Patient's address. Check here to ship to Prescriber's office.

☐ Check box if Prescriber will complete the embedded script below. All required (*) information must be completed. Print in legible capital letters. Write a prescription for up to 90 days with refills. NOTE: ALL CONTROLLED SUBSTANCE PRESCRIPTIONS MUST BE SUBMITTED ELECTRONICALLY AND SEPARATELY FROM THIS THIS ENROLLMENT FORM, AND MUST INCLUDE YOUR DEA NUMBER.

Section 2: PRESCRIPTION

*Patient's First Name: _____ M.I. _____ *Patient's Last Name: _____

*Date of Birth (mm/dd/yyyy): ____ /____ /_____ *Patient Phone: _____ ☐ Home ☐ Mobile

*Shipping Address: _____ *City _____ *State: _____ *Zip: ___ / ___ / ___ / ___ / ___

*Allergies: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa ☐ Other _____

*Medical Conditions: ☐ None ☐ Asthma ☐ Glaucoma ☐ Heart ☐ High BP ☐ Ulcer ☐ Other _____

*Current Medication(s) Being Taken by the Patient: _____

*Product Name: _____ *Strength: _____ Quantity: _____

*Directions: _____ Refills (For up to 1 year): _____

*Product Name: _____ *Strength: _____ Quantity: _____

*Directions: _____ Refills (For up to 1 year): _____

☐ Check box if Prescriber will electronically send a prescription to our mail order pharmacy, KnippeRx.
If you chose to e-scribe, this form still needs to be completed, signed and sent into Bausch Health PAP.
Pharmacy credentials to search your EMR/EHR system are as follows: **KnippeRx Pharmacy:** 1250 Patrol Rd., Suite 100, Charlestown, IN 47111 **Phone:** 855-647-7379 **Fax:** 855-774-3879

By signing, I am confirming that I have read, understood, and agree to the Prescriber Authorization and Release as written on Prescriber Application Page 4 (the following page).

Prescriber's Signature: **Date (mm/dd/yyyy):**

SIGN _____ DATE _____

THIS FORM SHOULD NOT BE TAMPERED WITH OR REVISED IN ANY WAY.
Accepting electronic/stamped/docu-signed signatures. Stamped signatures are not allowed for controlled substances.

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Prescriber Authorization and Release (Page 4)

I certify that in my professional medical judgment, this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize Bausch Health PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. I understand that the Bausch Health PAP reserves the right to modify or discontinue this program at this facility/practice or terminate assistance at any time and without notice.

I have determined, based on my independent clinical judgment, that the patient named on the application should be treated with the Bausch Health product(s) I have listed on the included prescription.

I confirm that:

- The patient is under my care on an outpatient basis and meets the clinical eligibility criteria for the prescribed product(s)
- I will not charge the patient any fee for enrollment or other activities associated with the patient's participation in the Bausch Health PAP
- I will not charge the patient for any professional services associated with the product(s) that are not covered by the patient's insurance provider or plan, or when the patient's costs associated with the prescribed product(s) represents a financial hardship and assistance has been approved by the Bausch Health PAP
- I will not make any claim to any third-party payer (e.g., Medicaid, Medicare, public or private insurance, etc.) for reimbursement of product(s) provided by the Bausch Health PAP
- I will not sell, trade or return for credit the product(s) provided by the Bausch Health PAP
- I am not prohibited from participating in federally funded health care programs nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General
- To the best of my knowledge, the patient does not have affordable third-party insurance coverage for the selected product(s) through, for example, an HMO, private insurance, a State pharmacy program, Medicare, Medicaid, or Veterans Assistance, and the patient meets all other Bausch Health PAP eligibility requirements

By signing this form, I authorize Bausch Health PAP as my designated agent on behalf of the patient, to forward the prescription for the product(s) selected and presented herein by fax or other mode of delivery to the Bausch Health PAP dispensing pharmacy or distributor for fulfillment and/or dispensing.

By including my email address on page 3, I agree to receive communication related to the Bausch Health PAP by email.

By including my fax number above, I acknowledge that any communication by, or on behalf of, the Bausch Health PAP in relation to this application or the participation of the applicant in the Bausch Health PAP delivered by fax machine to that fax number is not an unsolicited advertisement and I authorize the Bausch Health PAP, and anyone acting on its behalf, to communicate with me and my office through such means for that purpose.

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