Boehringer Ingelheim
CARES FOUNDATION

Patient Assistance Program Application Form

Hours: M-F, 8:30 am – 6:00 pm ET
Phone: 1-800-556-8317 | Fax: 1-866-851-2827

The Boehringer Cares Patient Assistance Program (the "Program") is provided by the Boehringer Ingelheim Cares Foundation ("BICF"), an independent nonprofit organization that seeks to help eligible patients receive the following medicines/products for free:

Aptivus® (tipranavir)

Atrovent® HFA (ipratropium bromide HFA)

Combivent® Respimat® (ipratropium bromide and albuterol)

Cyltezo® (adalimumab-adbm)

Gilotrif® (afatinib)

Glyxambi® (empagliflozin/linagliptin)

Hernexeos™ (zongertinib)

Jardiance® (empagliflozin)

Jascayd® (nerandomilast)

Jentadueto® (linagliptin/metformin HCl)

Jentadueto® XR (linagliptin/metformin HCl extended-release)

Ofev® (nintedanib)

Spiriva® Respimat® (tiotropium bromide)

Stiolto® Respimat® (tiotropium bromide and olodaterol)

Striverdi® Respimat® (olodaterol)

Synjardy® (empagliflozin/metformin HCl)

Synjardy® XR (empagliflozin/metformin HCl extended-release)

Tradjenta® (linagliptin)

Trijardy® XR (empagliflozin/linagliptin/metformin HCl extended-release)

Applying for the Program is FREE. There is no charge for submitting your application form.

Eligibility

All applications are reviewed in accordance with Program eligibility criteria. To be eligible, you must:

- Be a resident with a physical address within the United States or US Territory
- Have no health insurance or your insurance does not cover the medication
- Have Medicare but cannot afford your medication, and you do not qualify for Medicare's Extra-Help Program (Low Income Subsidy), except Cyltezo
- Not have access to alternate sources of coverage or funding for your medication
- Meet household income guidelines established by the Program
- Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or PayerMatrix, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the program. You agree to inform the Program if you are a member of such an insurance plan or if you are applying on behalf of a patient who is a member of such an insurance plan.

Note: BICF reserves the right to request additional documentation to verify the information provided in this form for purposes of determining Patient eligibility for assistance, and to conduct periodic audits of Patient's enrollment. Requested documentation may include items such as Federal Tax Return, W2, 1099, pension statement, Social Security statement, pay stubs, Proof of denial for the Medicare Part D LIS/Extra Help, or other documentation we deem necessary to determine patient eligibility. Missing information in the form, inability to verify information provided and delays in providing requested documentation may result in delays in processing the application and eligibility determinations.

Application Checklists

Patient

- ☐ Complete Section 1 – Check which product(s) you are applying for
- ☐ Complete Sections 2 - 4 – Fill out the Patient Information, Income Information, and Insurance Information
  Note: Proof of Income documents may be requested for verification purposes.
- ☐ Read and Sign Section 5 – Patient Attestation and Authorization

Prescriber

- ☐ Complete all applicable information in Section 6 - Prescriber Information
- ☐ Read and Sign Section 7 - Prescriber Attestation
- ☐ Submit a prescription to the Program
- ☐ Complete Section 9 if applicable
- ☐ Fax the application to 1-866-851-2827

Patient Please fill out all fields on this page in blue or black ink.

Section 1 Eligible Medicines/Products (check all that you are applying for)

- ☐ Aptivus®
- ☐ Atrovent® HFA
- ☐ Combivent® Respimat®
- ☐ Cyltezo®
- ☐ Gilotrif®
- ☐ Glyxambi®
- ☐ Hernexeos™
- ☐ Jardiance®
- ☐ Jascayd®
- ☐ Jentadueto®
- ☐ Jentadueto® XR
- ☐ Ofev®
- ☐ Spiriva® Respimat®
- ☐ Stiolto® Respimat®
- ☐ Striverdi® Respimat®
- ☐ Synjardy®
- ☐ Synjardy® XR
- ☐ Tradjenta®
- ☐ Trijardy® XR

Section 2 Patient Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ Male ☐ Female DOB (MM/DD/YYYY): _____ Last 4 Digits of SSN: _____

Email Address*: _____ Daytime Phone Number*: _____

* I understand this Program may include calls and emails from BICF and its third-party partners ("Partners"). These periodic communications are intended to provide timely updates regarding the status of your application and other information related to your participation in the Program.

Mobile Phone Number _____ Please send me Text Notifications on Mobile Phone: ☐ Yes[1] ☐ No

[1] YES, I agree to receive periodic messages from BICF and its Partners about my participation in the Program and other related information at the mobile number provided. I understand texts may be sent via an autodialer and are not a condition of enrollment in the Program. Standard message and data rates may apply.

Name of Patient's Authorized Representative (Optional): _____

Relationship to Patient: ☐ Family Member or Caregiver ☐ Other, Please Specify: _____

Section 3 Income Information

Number of people in your household (including yourself): _____ Total annual household income per year: _____

Section 4 Insurance Information (check all that apply)

☐ I do not currently have health insurance

Medicare: ☐ Part D ☐ Part B (☐ With Supplemental Insurance) ☐ Medicare Advantage Plan

Have you received a denial letter from Medicare Low Income Subsidy? ☐ Yes[2] ☐ No

[2] If yes, please attach a recent copy of this letter along with your application.

Other Insurance Types: ☐ Medicaid ☐ Veterans Affairs or Military ☐ Private Insurance (not Medicare Part D)

Medical Insurance:

Policyholder Name: _____

Group #: _____

Medical Insurance ID: _____

Prescription Insurance:

Member ID#: _____

Rx BIN: _____

Rx Group #: _____

Rx PCN: _____

Patient Please read and complete the signature at the bottom of the page.

Section 5 Patient Attestation and Authorization to Share Health Information

By signing the below, you, the Patient, attest and certify that:

- The information provided in this application and any additional information provided as a part of the application process is current, complete and accurate to the best of your knowledge.
- You cannot afford the medication requested and: (1) have no coverage; (2) have no coverage for the medication for which you've applied for support under the Program; or (3) have coverage for the medication but have an out-of-pocket expense you cannot afford.
- You will not seek reimbursement from any insurer or government program for any medication dispensed from the Program and you will immediately notify the Program if the medication requested is/are no longer medically necessary or if your insurance/financial status has changed.

In addition, by signing the below, you, the Patient, understand and agree that:

- Any medication supplied as a result of this Application is for your use only, and shall not be sold, traded, bartered, transferred or returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to you.
- The information provided in this Application is subject to random audits and verification. During such audits and verification processes, you may be asked for additional supporting documentation.
- The Boehringer Ingelheim Cares Foundation ("BICF") may change this Program at any time and reserves the right to terminate your enrollment at any time due to lack of eligibility or related factors.
- The medication made available to you under this Program may be denied if you do not fully cooperate with efforts made to verify the information provided in this application, or if you do not take steps to secure other forms of payment for your medication after being notified of other programs for which you may be eligible.

BICF is not obligated to verify any of the information contained in this Application or to confirm other medications that you are taking. By signing below, I give my permission to share my personal information with BICF, its representatives, agents, and other third-party partners supporting the administration of the Program, who may contact me with follow-up inquiries and who may report my personal information to health authorities to comply with applicable rules and regulations.

By signing this **Patient Authorization to Share Personal and Health Information** ("Authorization"), I authorize my healthcare practitioners, pharmacy providers, health plan, and insurers to disclose my protected health information, including, but not limited to, information relating to my medical condition, treatment, care management, health insurance, medication history, prescriptions, and all information provided on this form (collectively, "Personal and Health Information"), to BICF, its representatives, agents, and other third-party partners supporting the administration of the Program (collectively, "BICF and its Partners").

I understand that BICF and its Partners will use and disclose my Personal and Health Information for purposes including:

- To process my application for the Program, validate the information provided in this application, and verify my eligibility for participation in the Program, investigate and verify my insurance benefits and/or identify other patient assistance resources.
- To notify me if I do not meet the eligibility requirements or if there are any changes to the Program.
- If eligibility is confirmed, to facilitate my participation in the Program, which will include the dispensing and delivery of medication.
- To assist in the general administration of the Program and conduct any additional services described above and related to the Program.
- To comply with applicable rules and regulatory requirements related to safety information received in the course of administering the Program, where such information is collected in the interest of patient safety. Such information will be filed in a global database and the information may be reported to regulatory authorities.

I further understand that:

- BICF and its Partners have implemented reasonable safeguards to keep my Personal and Health Information secure, however the Personal and Health Information released under this Authorization may no longer be protected by federal privacy laws and may be lawfully re-disclosed by recipients.
- My physician, health insurance, and pharmacy providers may receive financial remuneration from BICF and its Partners for providing Personal and Health Information, which may be used for marketing purposes.
- BICF and its Partners will retain my Personal and Health Information for as long as permitted or required by applicable rules and regulations.
- I may revoke l this Authorization at any time by giving written notice to BICF at the address noted on this application, but that my revocation will not apply to any Personal or Health Information already used or disclosed under this Authorization and will only apply to future use of my Personal or Health Information.
- I am entitled to a copy of this Authorization from my healthcare practitioner and/or BICF, and that I may inspect/obtain a copy of my Personal and Health Information disclosed under to this Authorization.
- I can refuse to sign this Authorization and it will not impact the way my healthcare practitioners, pharmacy providers, health plan, and insurers treat me, but if I do not sign this Authorization, I will not be able to participate in the Program.
- This Authorization is valid from the date of its execution and will expire one year from the date of enrollment in the Program or the date I am notified I am ineligible for the Program, unless I revoke my Authorization earlier.

X	*Patient/Authorized Rep. Signature*	*Date*

Prescriber Please fill out all fields and complete the signature on this page in blue or black ink.

Section 6 Prescriber Information

Prescriber Name: _____ NPI: _____

Site/Facility Name: _____ Office Contact Name: _____

Address: _____ Email Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone Number: _____ Office Fax Number: _____

Prescription is required for eligibility in the Program. Please read options carefully, submit a prescription via one method only, and indicate method below.

☐ Prescription (page 5) included in the application form

☐ Electronic prescription (Select KnippeRx Pharmacy (NPI 1285159152) in the eRx software)

☐ Separate Prescriber-generated prescription (Fax to 1-866-851-2827)

Do not complete Section 8 if submitting an electronic prescription or faxing a separate prescriber-generated prescription. Please do complete Section 9 if applicable.

Section 7 Prescriber Attestation

The information you, the Prescriber, provides as part of this Boehringer Cares Patient Assistance Program Application ("Application") will be used by the Boehringer Ingelheim Cares Foundation, Inc. ("BICF") and its affiliates, agents, representatives and service providers to (1) process this Application and verify the information contained in this Application, (2) administer, analyze, and improve the Boehringer Cares Patient Assistance Program ("Program"), (3) improve and tailor our products and services to better serve you, (4) communicate with you about your experience with the Program, and/or (5) send you materials and other helpful information and updates relating to BICF programs ("Services").

By signing below, you, the Prescriber, attest and certify that:

- The information provided in this Application and any additional information provided as part of the Application process is current, complete, and accurate to the best of your knowledge.
- To the best of your knowledge, the patient identified in this Application cannot afford the medication requested and (1) has no coverage or (2) has no coverage for the medication or (3) has coverage for the medication but has an out-of-pocket expense he/she cannot afford.
- You will not seek reimbursement for any medication dispensed from the Program.
- You will notify the Program immediately if the medication requested is no longer medically necessary for this patient's treatment or if you become aware that your patient's insurance or financial status has changed.
- You have a signed copy on file of your patient's current and completed HIPAA Authorization, or any other authorization or consent required by law, so that you may share patient health information with the Program, including BICF and its affiliates, agents, representatives and service providers.

In addition, by signing below, you, the Prescriber, understand and agree that:

- Any medication supplied as a result of this Application is for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred or returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to your patient.
- The information provided in this Application is subject to random audits and verification.
- BICF may change this Program at any time and reserves the right to terminate your patient's enrollment at any time due to lack of eligibility or related factors.
- My signature indicates approval to dispense the prescription in Section 8.

X	*Prescriber Signature*	*Date*

(Original – Stamps NOT ACCEPTED)

Prescriber Please fill out all fields and complete the signature on this page in blue or black ink.

Section 8 Prescription & Medication Information

Patient First Name: _____ Patient Last Name: _____ DOB (MM/DD/YYYY): _____

Allergies: _____ ☐ No known allergies

Current Medications : _____ ☐ None

Health Conditions : _____

Which medicine/product are you prescribing? (Check all that apply)

Product	Strength	Directions	Quantity	Refills
☐ Aptivus®	250mg		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Atrovent® HFA	17mcg/act		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Combivent® Respimat®	20mcg/100cg per act		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Cyltezo®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Gilotrif®			60 Days	☐ 1 ☐ 2 ☐ 3
☐ Glyxambi®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Hernexeos™ for patients <90kg	120 mg (two 60mg tablets)		90 days	☐ 1 ☐ 2 ☐ 3
☐ Hernexeos™ for patients ≥90kg	180 mg (three 60mg tablets)		90 days	☐ 1 ☐ 2 ☐ 3
☐ Jardiance®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Jascayd®	9mg			☐ 1 ☐ 2 ☐ 3
☐ Jascayd®	18mg			☐ 1 ☐ 2 ☐ 3
☐ Jentadueto®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Jentadueto XR®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Ofev®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Spiriva® Respimat®	2.5mcg/act		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Spiriva® Respimat®	1.25mcg/act		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Stiolto® Respimat®	2.5mcg/2.5mcg per act		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Striverdi® Respimat®	2.5mcg/act		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Synjardy®			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Synjardy® XR			90 Days	☐ 1 ☐ 2 ☐ 3
☐ Tradjenta®	5mg tab		90 Days	☐ 1 ☐ 2 ☐ 3
☐ Trijardy® XR			90 Days	☐ 1 ☐ 2 ☐ 3

Prescriber Name: _____ NPI: _____

X	*Prescriber Signature*	*Date*

Section 9 Other Coverage information

If the patient is covered by Prescription Drug Coverage, please provide information below to help determine eligibility for the Program:

Was a formulary exception or prior authorization or prior authorization appeal submitted and denied? ☐ Yes ☐ No