NOURIANZ™ (istradefylline) Patient Assistance Program Application

Phone: 833-KK-CARES (833-552-2737) | Fax: 833-447-4399 | M-F, 8AM to 8PM EST
Mailing Address: 4700 Millenia Boulevard, Suite 500, Orlando, FL 32839

PAP Application must be completed in full, including signatures, to be reviewed for patient program eligibility.

- To be considered for the Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:
  - » Complete the Financial Information section below, and qualify for the program financial requirements.
  - » Be a permanent resident of the United States or Puerto Rico. Be fully uninsured (no health insurance or prescription drug insurance whatsoever).
  - » Requested product must be prescribed by a licensed U.S. healthcare professional for the Food and Drug Administration (FDA) approved indication.
- Applicants are individually assessed for program eligibility based on information provided within this application, and are only evaluated upon receipt of the completed and signed application.

* *Indicates a required field*

1. Patient Information

*Patient First Name: _____ *MI: _____

*Patient Last Name: _____

*DOB: _____ *Gender: ☐ M ☐ F ☐ Unspecified

*SSN (Last Four): _____ *Resident of the US or Puerto Rico: ☐ Yes ☐ No

Preferred Language: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

*Home Phone: _____ Cell Phone: _____

Email: _____

Caregiver Name: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Email

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

2. Prescriber Information

*Prescriber Name: _____ ☐ MD ☐ NP ☐ DO ☐ PA

Prescriber NPI #: _____

Facility Name: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone #: _____ Fax #: _____

*Primary Office Contact: _____

Office Contact Email: _____

3. Financial Information

(Documented Proof of Income is required if patient does not sign Electronic Income Verification Authorization)

*Total Annual Gross Household (HH) Income: $ _____

*Household Size (select one): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ _____

*Select Your Sources of Income: ☐ Salary/Wages ☐ Alimony/Child Support

☐ SS Pension/Unemployment ☐ Retirement ☐ SSDI ☐ SSI

☐ No Household Income *($0 – Provide a signed letter from the patient explaining zero income)*

☐ Other: _____

4. Clinical Information

*ICD 10: ☐ G20 Parkinson's Disease ☐ Other

*Allergies: _____

*Is the patient currently taking Levodopa/Carbidopa?: ☐ Yes ☐ No

*Current Meds: _____

_____

5. Prescriber Certification

I certify that the information provided in this Patient Assistance Program Application is complete and accurate to the best of my knowledge, that I have prescribed NOURIANZ™ below to the applicant based on my professional judgment of medical necessity for a Food and Drug Administration (FDA) approved indication, and that I will supervise the patient's medical treatment. I will notify Kyowa Kirin Cares immediately if the Kyowa Kirin product is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorizations for the release of my patient's personal identification and insurance information to Kyowa Kirin and their agents and representatives. I understand that any information provided is for the sole use of Kyowa Kirin and their agents and representatives to verify my patient's insurance coverage status, to assess, if applicable, patient's eligibility for participation in the Kyowa Kirin Cares Patient Assistance, and to otherwise administer the Program and provide related services. I understand that application to the Program does not guarantee that assistance will be obtained. I understand that Kyowa Kirin may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Program, and I agree to immediately notify a Kyowa Kirin Cares representative if I become aware of changes in the patient's insurance status. I agree that Kyowa Kirin Cares may contact me for additional information relating to this application either by fax, e-mail and/or telephone. I understand that I am under no obligation to prescribe any Kyowa Kirin product and that I have not received, nor will I receive any benefit from Kyowa Kirin or their agents or representatives for prescribing a Kyowa Kirin product. I agree that I will not submit claims or make any attempt to receive reimbursement for product provided by the Program. By signing this Patient Assistance Program Application, I authorize the release of medical and/or other patient information relating to NOURIANZ™ therapy to agents, and service providers of Kyowa Kirin (including but not limited to AssistRx and NOURIANZ™ dispensing pharmacies) to use and disclose as necessary for verification of patient eligibility, and to furnish any information on this form to the insurer of the applicant for the purpose of verifying benefit eligibility.

6. Prescription for NOURIANZ™

Rx: NOURIANZ™

Dispense: (Please select one option below)

☐ 20mg tablets or ☐ 40mg tablets

Quantity: ☐ 90 tablets ☐ _____ tablets

SIG: Take one (1) tablet daily Refills #: _____

Please sign and date below:

*Dispense As Written: _____

*Substitution Permitted: _____

*Date: _____

*STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms*

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Patient Name: _____ DOB: _____

* *Indicates a required field*

7. Patient Authorization and Agreement

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for NOURIANZ™ and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Kyowa Kirin, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Kyowa Kirin") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting Kyowa Kirin Cares Support Services (the "Program") for Healthcare Providers and patients for the purposes described below.

a. Specifically, I authorize disclosure of my Protected Health Information in order to:

b. Enroll me in, and contact me about the Program, including online support, financial assistance services, co-pay assistance, nurse services, compliance and persistency services, and electronic communication including emails and text messages,

c. Communicate with my Healthcare Providers and Insurers about benefits, coverage and medical care, including compliance with Product treatments,

d. Locate a specialty pharmacy that can fill my prescription and facilitate dispensing of my prescription by such pharmacy,

e. Provide me with educational materials, information and services related to my treatment experience with NOURIANZ™ and my condition,

f. Contact me and leave messages about my use of NOURIANZ™ and my medical care,

g. Verify, investigate, assist with, and coordinate my coverage for NOURIANZ™ with my Insurers,

h. Coordinate prescription fulfillment and share prescription information,

i. Conduct surveys, data analytics, market research and other internal business activities related to the Program, NOURIANZ™, and other Kyowa Kirin products and programs, and

j. Contact me as otherwise required or permitted by law.

I understand that pharmacies that ship my medication may be paid to share this information with the Program to help provide the offerings requested for me. Once my Protected Health Information has been disclosed to Kyowa Kirin, I understand that federal privacy laws no longer protect the information. However, Kyowa Kirin agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law.

I understand that I am providing 'written instructions' to Kyowa Kirin and its vendor AssistRx under the Fair Credit Reporting Act authorizing AssistRx on behalf of Kyowa Kirin to obtain information from my credit profile or other information from consumer credit agencies. I authorize Kyowa Kirin and its partnered provider AssistRx to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial screening process.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided by Kyowa Kirin under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

This Authorization will last for a period of five (5) years (unless earlier termination is required by applicable state law). I understand that I may cancel this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by mailing a request to 4700 Millenia Boulevard, Suite 500, Orlando, FL 32839, via fax at 833-447-4399, or by calling 833-552-2737. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

The personal and health insurance I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this Form changes by contacting the Program at 833-552-2737.

My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

*Patient Name: _____ *Signature: _____ *Date: _____

Please Print

8. Patient Authorized Representative

I permit Kyowa Kirin Cares Support Services representatives to speak with the following person about this enrollment form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, insurance appeals, or any other treatment related issues. I may cancel this authorization at any time by calling: 833-552-2737.

Name of Authorized Representative: _____ Relationship to Patient: _____

Phone Number: _____ Email: _____

By signing below, I, the patient named above, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

*Patient Signature: _____ *Date: _____