AZURITY
PHARMACEUTICALS, INC.

Katerzia® (amlodipine) Oral Solution
Patient Assistance Program

Service(s) Requested	
Patient Assistance Requested for: ❑ Katerzia® Oral Solution, 1 mg/mL	ICD-10 Code for Primary Diagnosis: ICD-10 Code for Secondary Diagnosis:

Patient Information (please print)			
Patient Name:			
Address:			
City:	State:	Zip:	Phone:
Primary Contact:	Relationship:	Email:	
SSN:	DOB:	Gender:	US Resident:
Patient Language: English ❑ Spanish ❑ Other:			

Total Household Income (Attach Documentation for Each Source Listed)			
Salary Wages: $	Social Security Disability: $	Rental Income: $	Pension/Retirement: $
Social Security Retirement: $	Unemployment $	Workers Compensation: $	Other: $
Supplemental Security Income: $	Alimony/Child Support: $	Veterans Benefits: $	**Total: $**
Household Size (Number of persons who contribute to and/or are dependent on patient's household income):			

Insurance Information (Y=Yes, N=No, P=Pending or Wait Listed) (Attach Proof of Insurance)					
Insurer/Payer/Program	Rx Benefits	Medical Benefits	Insurer/Payer/Program	Rx Benefits	Medical Benefits
Medicare (Traditional or Supplemental)	❑ Y ❑ N ❑ P	❑ Y ❑ N ❑ P	Private Insurance	❑ Y ❑ N ❑ P	❑ Y ❑ N ❑ P
Medicaid	❑ Y ❑ N ❑ P	❑ Y ❑ N ❑ P			
Primary Insurance Company:		Phone #:		Policy ID #	Group#
Contact Name at Insurance (if applicable):				Phone #:	
Subscriber Name:				Date of Birth:	
Secondary Insurance: Does applicant have additional coverage? ❑ Y ❑ N If YES, provide name, telephone and policy numbers:			Has applicant applied to Medicaid? ❑ Y ❑ N If YES, date of application:_____ Is applicant eligible? ❑ Y ❑ N If NO, state reason:_____ Currently enrolled in Medicare Part D? ❑ Y ❑ N Has applicant applied to Medicare? ❑ Y ❑ N Is applicant eligible? ❑ Y ❑ N		

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Applicant Declaration

I verify that the information provided on this application is complete and accurate. I understand that the Katerzia® Patient Assistance Program may request documentation to verify financial or insurance information and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that Azurity Pharmaceuticals, Inc. reserves the right at any time and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

I authorize my healthcare providers and health plans to disclose personal and medical information about me to Azurity Pharmaceuticals and its agents and contractors ("Azurity"), and I authorize Azurity to use, share and disclose this information to: 1) establish my benefit eligibility; 2) provide support services, including facilitating the provision of Azurity medication to me; and to contact me to evaluate therapy and the effectiveness of the program.

I understand that once my health information has been disclosed to Azurity, privacy laws may no longer restrict its use or disclosure; however, Azurity agrees to protect my information by using and disclosing it only for the purposes described above or as required by law.
I further understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my doctor will not change, but I will not have access to the services available through this program. I may cancel this authorization at any time by notifying Azurity in writing and submitting it by fax to 1-866-927-2052 or by calling 1-844-472-2032. If I cancel, Azurity will stop using or disclosing my information for the purposes listed above, except as required by law or as necessary for the orderly termination of my participation in this program. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient or Legal Guardian's Signature:_____ **Date:**_____

Prescriber Information (please print)

Name:		Title:
Facility Name:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	
State License #:	DEA #:	NPI #:

Patient Advocate Information (if Different from Prescriber)

Name:		Title:
Facility Name:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	
State License Type and Number (if applicable):		

A Patient Advocate may be a healthcare worker involved in the patient's care – a physician, nurse, physician assistant, social worker or case manager. Friends or family members cannot act as Patient Advocates. Patient Advocates are responsible for assisting in completing the patient Enrollment Form and working with the patient at specific intervals in the enrollment process.

Statement of Medical Necessity for Financially Needy Patients

To the best of my knowledge, this patient has no coverage (including Medicaid or other public programs) for Katerzia®. I certify that the medication(s) listed above are medically indicated for this patient and that I will be supervising the patient's treatment. As part of my patient's eligibility, I agree to periodically verify continued use of Azurity medication and resubmit current prescriptions.

Signature_____Date_____

Prescriber ❑ Patient Advocate ❑

Applications are considered complete only if they include all of the following:

- ☐ Completed Enrollment Form (2 pages)
- ☐ Patient as well as Prescriber or Patient Advocate Signatures
- ☐ Documentation of Income Sources and Residency

When complete, fax or mail application and documentation to:

Attn: Azurity PAP
1710 N Shelby Oaks Dr. #1
Memphis, TN 38134
Fax: (866) 927-2052; Phone: (844) 472-2032