EPIDIOLEX® (cannabidiol) Patient Assistance Program (PAP)

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JazzCares®
Making a difference in Patients' lives, one Patient at a time

Complete and submit this application to determine a patient's eligibility to receive EPIDIOLEX through the Jazz Pharmaceuticals Patient Assistance Program. All fields are required unless noted as optional.

How to apply for the Patient Assistance Program

Healthcare providers and legal guardians/patients should ensure the following steps are completed:

Step 1: Complete all sections of this application. Please include details regarding why the patient is seeking patient assistance, along with details and documentation of any previous attempts to obtain coverage through insurance, if applicable.

Step 2: Provide your signature where requested, applicable to the Healthcare Provider and Legal Guardian/Patient.

Step 3: Fax the completed application to JazzCares® at 1-855-518-7566. If you are unable to fax this application, please call 1-833-426-4243 and speak with an associate about an alternative submission method.

Step 4: Submit a valid prescription, including any necessary titration instructions, for a 90 days' supply (if appropriate/allowed by state law) of EPIDIOLEX to the JazzCares Pharmacy by faxing to 1-855-518-7566 or e-prescribing to JazzCares Pharmacy, (PharmaCord, 11001 Bluegrass Parkway, Suite 200, Louisville, KY 40299, NCPDP #1836191).

For additional assistance, call us at 1-833-426-4243.

SECTION 1: PRESCRIBER INFORMATION

Prescriber Name: _____ Title: _____ Specialty: _____

NPI #: _____ DEA #: _____ State License #: _____

Office Contact Name: _____ Contact Phone: _____

Contact Fax: _____ Contact Email: _____

Preferred Method of Contact: Primary: ☐ Phone ☐ Fax ☐ Email Secondary: ☐ Phone ☐ Fax ☐ Email

Practice Name: _____ Office Address: _____

City/State/Zip code: _____

SECTION 2: PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Height: _____ Weight: _____ kg

Current Medications: _____

Known Allergies: _____ ☐ No Known Allergies

Diagnosis: The diagnosis designations below are intended to ensure communication of accurate information to the appropriate parties in this application process. **EPIDIOLEX is approved to treat seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex in patients 1 year of age and older. Please click for full Prescribing Information.**

ICD-10 Code: _____

Seizures associated with: ☐ Lennox-Gastaut syndrome ☐ Dravet syndrome ☐ Tuberous sclerosis complex

☐ Other (please specify): _____ **Are patient's seizures refractory in nature?** ☐ Y ☐ N

If choosing "other," and this medication is being prescribed for a use that is not listed on the FDA-approved label, by signing this patient enrollment form, I certify that the Prescriber has determined that EPIDIOLEX is medically necessary and appropriate for this patient and this patient's treatment will be supervised.

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SECTION 2: PATIENT INFORMATION *(continued)*

As the undersigned Prescriber, or the Prescriber's Designated Agent, I hereby authorize the use or disclosure of the patient's health information contained on this enrollment form to the patient's other healthcare providers (including pharmacies and Jazz Pharmaceuticals, Inc.), their respective agents and contractors and other designees that are involved in the patient's treatment ("Providers") and health plans or insurers and their respective agents and designees ("Insurers") to: (1) determine the patient's insurance benefits for EPIDIOLEX; (2) transmit the necessary information to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (3) contact the patient to obtain any necessary signatures, consents or information relating to the patient's treatment; (4) contact the patient in order to ask whether the patient would like to apply for the Jazz Pharmaceuticals Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; and (5) to provide other related care coordination services.

I certify that the patient's authorization to use and disclose the patient's personally identifiable health information for the purposes permitted under this "Healthcare Provider Authorization" section has been obtained, as required by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Designated Agent, as applicable, for additional information as needed relating to the patient's EPIDIOLEX therapy. The undersigned certifies that: (1) the Prescriber has prescribed EPIDIOLEX for the identified patient; (2) the Prescriber has determined that EPIDIOLEX is medically necessary for this patient; (3) if the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.

Signature: _____ Date: _____ Name/Title (if Designated Agent): _____

Patient Full Name: _____ Patient Date of Birth: _____

Patient Address: _____ City/State/Zip: _____

Group Home/Long-Term Care Facility? ☐ Y ☐ N If Yes, Facility Name and Contact: _____

Full Name of Legal Guardian: _____

Primary Phone: _____ ☐ Home ☐ Mobile ☐ Other Email: _____

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Other

SECTION 3: FINANCIAL INFORMATION *(to be completed by patient or legal guardian)*

Total Annual Household Income: _____

Total Number of People Within Household (including applicant): _____

By signing within Section 3, the information within this application will be used to run an income validation using a third-party financial services company to verify income.

Signature of Patient or Guardian, if Applicable: _____ Date: _____

Name (if Different from Patient): _____ Relationship to Patient: _____

If you choose not to sign within this section, income documentation specified below must be provided.

☐ Most recent federal tax return ☐ W-2 form ☐ SSA-1099 ☐ Most recent 2 pay stubs

SECTION 4: INSURANCE INFORMATION

Has this patient's prescription already been processed by a Specialty Pharmacy? ☐ Yes ☐ No

Has patient's employer, insurance company, or another third party (e.g., SHARx, Paydhealth, Payer Matrix, among other names) directed you to apply to the JazzCares Patient Assistance Program? ☐ Yes ☐ No

Why is the patient seeking assistance? _____

Does the patient have prescription drug and/or medical insurance benefits? ☐ Yes ☐ No

If yes, has the patient experienced a previous denial of coverage for EPIDIOLEX? ☐ Yes ☐ No

If so, please describe the steps taken to attempt coverage through the patient's insurance: _____

_____

Please include all written documentation of denials from patient's insurance provider, with this application. Documentation from third-party alternative funding or specialty carve-out programs may not be accepted and/or subject to additional review.

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SECTION 5: HIPAA PATIENT AUTHORIZATION

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose the following information ("Personal Information") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares® program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs.

I understand and authorize Jazz Pharmaceuticals to use and further disclose the Personal Information it receives as a result of this Form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the JazzCares program or any other Jazz-affiliated patient support services and activities related to my condition or treatment; (ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products; (iii) coordinating my receipt of and payment for Jazz Pharmaceuticals' products; (iv) contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my Personal Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (vi) de-identifying my Personal Information by aggregating it for research purposes; (vii) managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand and authorize Jazz Pharmaceuticals to contact me using the contact information provided to Jazz to enroll me in, operate, and administer any Jazz-sponsored patient support services, including the JazzCares program, through a variety of means including email, postal mail, phone, fax or SMS/text unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Jazz contact me by telephone or SMS/text.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Jazz Pharmaceuticals may create or receive. I understand that my health insurer(s), Pharmacy, and third-party vendor(s) may receive remuneration (payment) in exchange for disclosing my Personal Information to Jazz Pharmaceuticals (including JazzCares, its affiliates, and vendors who help provide the services) and/or for providing me with support services for the purposes described above.

I understand that after my Personal Information is transmitted to Jazz Pharmaceuticals, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, Jazz Pharmaceuticals will not disclose my Personal Information to a third party that is not related to the patient support programs (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my Personal Information, I understand the receiver may not be subject to HIPAA or other privacy laws and the Personal Information might be re-disclosed by the recipient.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s) and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I can revoke this Form at any time in the future, but if I do so, I may no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

I understand that should I revoke this Form; the revocation will not impact uses and disclosures of my Personal Information that have already occurred in reliance on this Form. This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares program, unless a shorter time is required by state law. I can also revoke it earlier by calling 1-866-997-3688 or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589. I understand the program may be changed or ended at any time without prior notification. I understand I may request a copy of this Form that is on file with Jazz.

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at https://www.jazzpharma.com/privacy-statement/. If you are a resident of California, a description of the Personal Information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: https://www.jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/. I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient Name: _____ Date of Birth: _____

Signature of Patient or Guardian, if Applicable: _____ Date: _____

Name (if Different from Patient): _____ Relationship to Patient: _____

☐ **Check here if legal guardian/patient is unavailable to provide a signature.**
The JazzCares Team will contact the legal guardian/patient to obtain authorization.