ENDARI™
L-glutamine oral powder

Emmaus MEDICAL, INC.

Commercial Copayment Assistance Program
Patient Financial Assistance Application

Patient Name: _____Date: _____

Patient Address: _____

State: _____ City: _____ Zip: _____

Home Phone Number: _____ Patient's Cell Phone Number: _____

Patient/Parent E-mail: _____ Parent's Cell Number: _____

Best Method to Contact: _____

Patient's DOB: _____ Patient's Social Security No: _____

Are you a current resident of the United States, Puerto Rico, or U.S. Territories? The Endari Commercial Copayment Assistance Program is available only to residents of the United States, U.S. Territories, or the Commonwealth of Puerto Rico.

Yes ☐ No ☐

Are your prescriptions paid for in part or in full under any state or federally funded program, including but not limited to Medicare or Medicaid, Medigap, VA, DOD, or TRICARE? The Endari Commercial Copayment Assistance Program is available only to patients who currently do not participate in state or federally funded programs.

Yes ☐ No ☐

If Patient is a minor, please fill out the information requested below:

Name of Parent or Caretaker: _____

Relationship to Patient: _____

Employer Name: _____

Health Insurance Provider Name: _____

Please Provide a Copy of Your Driver's License or State Issued Identification along with your Health Insurance and Pharmacy Benefit Card

Pharmacy Name: _____

Pharmacy Address: _____

State: _____ City: _____ Zip: _____

Pharmacy Phone Number: _____ Pharmacy Contact: _____

Reason for Requesting Financial Assistance:

_____

_____

_____

Patient (Parent or Guardian if Minor) Insurance Attestation:
I hereby certify that my prescriptions are not paid for in part or in full under any state or federally funded program, including but not limited to Medicare or Medicaid, Medigap, VA, DOD, or TRICARE. I certify that if I begin receiving prescription benefits from such state, federal, or government-funded program at any time, I will no longer be eligible for the Endari Commercial Copayment Assistance Program.

Patient/Parent Signature: _____ Date: _____

Patient (Parent or Guardian if Minor) Financial Need Attestation Statement:
I hereby certify that the information contained in this application is accurate and that I require financial assistance to help cover my monthly copayments and coinsurance out-of-pocket costs associated with my Endari prescription. I certify that I am a United States citizen or legal resident and that I am not receiving any other form of financial support for Endari.

Patient/Parent Signature: _____ Date: _____

Patient (Parent or Guardian if Minor) Consent to Share Certain Personal Health Information:
I hereby authorize pharmacy to use and/or disclose (release) my personal health information for the limited purpose of determining my eligibility for the Endari Commercial Co-Payment Assistance Program. Such information will include: the date the prescription is filled, the number of pills or product dispensed by the pharmacy, and the amount of co-pay that will be paid for by using this Program. This authorization will expire twelve (12) months after the date of signing of this form. I understand that by signing this authorization:

- I authorize the use or disclosure of my individual identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand that this authorization may be revoked in writing at any time and is effective upon receipt. Written revocation will not affect any action taken in reliance on this authorization before the revocation is received.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

Patient/Parent Signature: _____ Date: _____

Pharmacy Attestation Statement:
I hereby certify that the information provided to Emmaus by the pharmacy is accurate and complete.

Pharmacy Contact Name: (Print Clearly) _____

Pharmacy Signature: _____ Date: _____

For Internal Use Only:
Emmaus Assigned Copay Identification Number: _____

Financial Assistance Approved: Yes: _____ No: _____

Amount Approved: _____ Months Approved: _____

Approved By: _____

Please fax the completed application to: 1-424-247-2075 or email: CoPay@EndariRx.com
Endari Commercial Copayment Assistance Program Support Services 1-855-723-5646

INDICATION:

Endari is indicated to reduce the acute complications of sickle cell disease in adult and children 5 years of age and older.

IMPORTANT SAFETY INFORMATION:

The most common side effects in clinical studies were constipation, nausea, headache, pain in the stomach area, cough, pain in hands or feet, back pain, and chest pain.

Side effects that lead to a stop in treatment during the clinical study were, one case each of overactive spleen (an organ that helps filter your blood), pain in the stomach area, indigestion, burning sensation, and hot flash.

It is not known whether Endari is safe and effective in children with sickle cell disease younger than 5 years old.

Talk to your doctor to determine if prescription Endari is right for you.

For more information, please read the Full Prescribing Information for Endari.

Terms and Conditions

- The Endari Commercial Copayment Assistance Program ("Program") can be used only by eligible residents of the U.S., Puerto Rico, or U.S. territories at participating eligible Network Pharmacies. Product must originate in the U.S., Puerto Rico, or U.S. territories. You must be 18 years or older to use the Program for yourself or a minor.
- The Program is limited to one per person and is not transferable. No substitutions are permitted. This Program is available for each valid prescription. No other purchase is necessary. The offer cannot be combined with any other coupon, free trial, discount, prescription savings card, or other offer.
- **The Program is not insurance and is not intended to substitute for insurance.**
- **The Program is valid only for patients with commercial insurance and is not valid for prescriptions that are eligible to be reimbursed:**
    - **in whole or part, by Medicare, Medicaid or a Medicare part D plan, TRICARE, VA, DOD, Puerto Rico government health insurance plan, or any other federal or state-funded healthcare benefit program (collectively, "Government Programs");**
    - **or by commercial plans or other health or pharmacy benefit programs that reimburse for the entire cost of prescription drugs.**
- Patients without insurance coverage are considered "cash-pay" patients. Medicare Part D enrollees who are in the prescription drug coverage gap (the "donut hole") are not eligible for the Program. Patients who begin receiving prescription benefits from such Government Programs at any time will no longer be eligible to use the Program. Void where prohibited by law, taxed, or restricted.
- Patient, pharmacist, and prescriber agree not to seek reimbursement for all or any part of the benefit received by the patient through the offer. Both patient and pharmacist are each individually responsible for reporting receipt of Program benefit to any insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled using the Program, as required.
- Information pertaining to your use of the Program will be shared with Emmaus, the sponsor of the Program, and its affiliates. The information disclosed will include the date the prescription is filled, the number of pills or product dispensed by the pharmacists, and the amount of your co-pay that will be paid for by using this Program.
- Patient is required to pay the first $10.00 of their monthly co-payment for Endari.
- Emmaus reserves the right to terminate, rescind, revoke, or modify this Program at any time without notice.