WD Rx Access Program Enrollment Form

The WD Rx Access Program helps patients secure access to SYPRINE® (trientine hydrochloride) capsules, if and when your healthcare provider prescribes it. WD Rx Access Program offers the following services:

Reimbursement Counseling: At Patient request, WD Rx Access Program will investigate insurance coverage availability for SYPRINE. This service includes information regarding the prior-authorization process, if applicable, as well as the claim denial/appeal process.

Copay Assistance: Patients who have coverage for SYPRINE through their commercial insurance may be eligible to receive the prescribed product for as low as $25. Patients who have commercial insurance but whose plan does not cover the product may also be eligible for alternate assistance. **Patients without insurance coverage or who may meet certain income-based eligibility requirements can find further information in the "Patient Assistance" section below.**

- WD Rx Access Program is a copay savings program only valid for individuals with commercial insurance. WD Rx Access Program is not valid for any person eligible for reimbursement of prescriptions, in whole or in part, by any federal, state, or other governmental programs, including, but not limited to, Medicare (including Medicare Advantage and Part A, B, and D plans), Medicaid, TRICARE, Veterans Administration or Department of Defense health coverage, CHAMPUS, the Puerto Rico Government Health Insurance Plan or any other federal or state health care programs. These patients may qualify for alternative financial assistance. This offer is good only in the United States of America (including the District of Columbia, Puerto Rico and the U.S. Virgin Islands). This offer is not available for individuals who live in Massachusetts and/or who have insurance coverage for prescriptions in Massachusetts. California residents and/or individuals who have insurance coverage for prescriptions in California may not be eligible to participate in the program unless they have a prior authorization or are otherwise eligible under California law. This offer is only good for SYPRINE®. No other purchases necessary. This offer is not health insurance. The patient agrees not to seek reimbursement for all or any part of the benefit received through this offer and is responsible for making any required reports of his/her use of this offer to any insurer or any third party who pays any part of this prescription filled. Patient must be 18 years of age or older to redeem this offer. This offer is not transferable. This offer is not valid with other offers. This offer has no cash value. The patient is responsible for paying the first $5 for each eligible prescription fill. There is a maximum benefit for the program, and the patient is responsible for all additional costs and expenses after the maximum benefit limit is reached. The patient understands and agrees to comply with the terms and conditions of this offer. Program term eligibility expires December 31, 2024. Bausch Health reserves the right to rescind, revoke, terminate, or amend this offer at any time, with or without notice. For more information, call a WD Rx Access Program representative at 888-607-7267.

All services offered through the WD Rx Access Program listed above require a completed enrollment form containing both patient and prescribing healthcare provider signatures. Completed enrollment forms can be mailed or faxed to:

WD Rx Access Program
PO Box 220667
Charlotte, NC 28222-0667
Fax: (855) 735-4624

If patients have any questions about the WD Rx Access Program application process, **please call (888) 607-7267**. WD Rx Access Program representatives are available Monday through Friday, 8:00 AM – 6:00 PM, Eastern Standard Time.

Patient Assistance Program: Subject to eligibility requirements, patients who are not eligible for savings under the WD Rx Access Program may alternatively be considered for the Bausch Health Patient Assistance Program (PAP).

- Under the PAP, patients without insurance coverage or otherwise meeting the PAP's requirements may be provided product by Bausch Health at no cost if they meet certain pre-established income level and other eligibility criteria.

- Patients can find further information on the PAP's eligibility criteria and other terms and conditions, as well as instructions for applying for free product under the PAP by visiting www.bauschhealthpap.com.

WD Rx Access Program
Enrollment Form

Return this completed application with a valid prescription to:

WD Rx Access Program

PO Box 220667, Charlotte, NC 28222-0667

Telephone: (888) 607-7267 Fax: (855) 735-4624

PATIENT INFORMATION

Patient Name: _____DOB_____

Address: _____City: _____ State: _____ Zip: _____

Day Phone: _____Evening Phone: _____

☐ Yes, I authorize messages to be left on my voicemail regarding the information I've provided and the status of my prescription.

DELIVERY INFORMATION (Please indicate shipping address if different from above)

Address: _____ City: _____ State: _____ Zip: _____

Delivery Contact Name: _____ Contact Phone: _____

INSURANCE INFORMATION (complete or include demographic sheet)

Primary Insurance (Include Medicare information, if applicable)

Insurance Company Name: _____ Policy ID #:_____Group #:_____

Phone #: _____Subscriber Name: _____Date of Birth: _____

Prescription Card #: _____Carrier:_____ Rx Card Phone#: _____

Secondary Insurance (Include Medicare information, if applicable)

Insurance Company Name: _____ Policy ID #:_____Group #:_____

Phone #: _____Subscriber Name: _____Date of Birth: _____

Prescription Card #: _____Carrier:_____ Rx Card Phone#: _____

FINANCIAL INFORMATION (Patient Assistance Only)

Current gross annual household income: $_____ Number of members in household: _____

Income Verification Source: ☐ 1040 ☐ W-2 ☐ Social Security Benefit Statement

I, _____ (patient's name) verify that the information provided in this application is complete and accurate. I do not have the financial resources to pay for product. I agree that if I am eligible and receive any free product, I understand and agree that I may not file for reimbursement under Medicaid, a Medicare drug benefit plan, or any other federal or state programs (such as medical assistance programs). I understand that I am responsible for reporting receipt of this offer to any health insurer, health plan, or third-party payer as may be required. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria and other terms and conditions of the Bausch Health Patient Assistance Program detailed at https://www.bauschhealthpap.com/eligibility#. I also understand that Bausch Health 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.

PATIENT AUTHORIZATION (Required)

I authorize my healthcare providers and health plans to disclose my protected health information ("PHI") to The Lash Group, LLC ("Lash") as the operator of the WD Rx Access Program to: (1) establish my eligibility for benefits through the WD Rx Access Program; (2) communicate with my healthcare providers and me about my medical care; and (3) provide support services including facilitating the provision of product to me. I understand that once my PHI has been disclosed to Lash, federal privacy laws may no longer restrict its further disclosure. Lash agrees to use and disclose this information only for the above purposes and as permitted by law.

I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Lash in writing and submitting the cancellation by fax to: (855) 735-4624, or by mail to PO Box 220667 Charlotte, NC 28222-0667. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires ten (10) years from the date it is signed by me.

WD RX Access

Patient Signature:_____ **Date:**_____

PROVIDER INFORMATION

Provider Name: _____

NPI#: _____ DEA #: _____

Tax ID# / Provider ID #:_____ State License #:_____

Site/Facility Name: _____

Street Address: _____

City: _____ State:_____ Zip: _____

Phone: _____ Fax: _____

Contact Name: _____

CLINICAL INFORMATION (Please Attach Valid Prescription to Form)

Diagnosis Code(s): _____

PROVIDER CERTIFICATION (Required)

My signature below indicates my (1) certification that SYPRINE® (trientine hydrochloride) capsules (the "Product") is medically necessary for this patient and I will be supervising the patient's treatments, (2) authorization for The Lash Group, LLC ("Lash") as the operator of the WD RX Access Program, to obtain, use and disclose protected health information as defined in 45 CFR 160.103 ("PHI") about my patient, to and from (a) patient's insurer, including eligibility and other benefit information for the WD Rx Access Program, and (b) healthcare providers, such as pharmacies and specialty pharmacies (together "SPs"), for treatment purposes, including to forward the prescription and associated PHI to a valid SP and to track the status of medications dispensed by SPs for my patient for coordination of care and related purposes, and (3) certification that I have received all necessary permission from such patient and other parties to permit the disclosure and use of the patient's PHI as described in this paragraph. Lash may de-identify, use and disclose PHI of my patient to the extent allowed by 45 CFR 164.504, provided that the de-identification complies with the requirements of 45 CFR 164.514(b). Lash shall maintain administrative, technical and physical safeguards to ensure the availability, integrity and confidentiality of PHI and shall notify me of any impermissible use or disclosure Security Incident and Breach of Unsecured PHI as required by law. This agreement incorporates and Lash agrees to comply with the requirements of 45 CFR 164.504 and 164.314(a)(2). I understand that my patient's application to the WD Rx Access Program does not guarantee that my patient will receive assistance. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the WD Rx Access Program, and I agree to immediately notify WD Rx Access Program if I become aware of such a change in status. I understand that I am under no obligation to prescribe Product and that I have not received, nor will I receive, any benefit from Bausch Health or its agents or representatives for prescribing Product. This agreement shall terminate upon any material violation of this agreement by Lash, upon my or my patient's written request, or two years after the signature date below. Upon termination, Lash shall destroy PHI in its possession.

☐ I have received written and/or oral authorization from my patient to act as his/her agent for disclosure and use of PHI as noted above and for the delivery receipt, storage, and administration of his/her Product.

☐ I agree to receive faxes and/or other communications regarding the WD Rx Access Program.

Provider Signature: _____ **Date:** _____

Supervising Physician: _____ **Date:**_____

No Stamps. Physician signature required
NY Prescriptions must be submitted on NY State Rx form