Sucraid® (sacrosidase) Oral Solution

PAP Application Form

Patient Assistance Program

Need Help?
SucraidASSIST™
Phone: 1-800-705-1962

Fax: 1-866-850-9155 Mail: Optum Frontier Therapies, 6425 Santa Margarita St. #110, Las Vegas, NV 89118 Email: Patientassistanceprogram@optum.com

Do I Qualify for Patient Assistance Program (PAP)? To qualify for assistance, you must:

- Have been prescribed Sucraid® (sacrosidase) Oral Solution
- Live in the United States or a US territory
- Have no prescription coverage or not enough coverage to pay for Sucraid®
- Meet certain income limits (Income eligibility starts at 200% of the federal poverty level and varies by household size. Income eligibility will be assessed upon receipt of your completed application.)

How Can I Apply? Please follow the checklist below when submitting your application:

- Fill out and sign the patient section of this enrollment form.

To be considered for the Patient Assistance Program (PAP), you will need the following:

- Completed and signed PAP application (this form)
- A photocopy of one of the following documents that shows your total annual household income:
  - Previous year's federal tax return (form 1040 or 1040EZ)
  - Wage and tax statements (W-2 forms)
  - Two recent paycheck stubs
  - Social security, pension, or railroad retirement statements (SSA-1099 or similar)
  - Statements of interest, dividends, or other income (1099-INT, 1099, 1099-DIV, or similar forms)

Make a photocopy of your application and income documentation (it may not be returned to you). Fax, mail, or email your application to:
Fax: 1-866-850-9155 Mail: Optum Frontier Therapies, 6425 Santa Margarita St. #110, Las Vegas, NV 89118 Email: Patientassistanceprogram@optum.com
If you need immediate assistance or have questions regarding any of the above, please call 1-800-705-1962.

Patient Information

Total Number of People Within Household (including applicant): | Total Annual Income for Entire Household:

Please submit documentation to support the financial information you've listed. Attached is:

☐ Most recent federal tax return ☐ W-2 form ☐ Other

Prescription Coverage and Insurance Information

Medication assistance is dependent on your ability to meet the eligibility criteria for our program as determined by Sucraid*ASSIST*™. Sucraid*ASSIST*™ does not have any obligation to provide the program services to you and is not liable in the provision of these services. Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the Sucraid*ASSIST*™ program. You agree to inform Sucraid*ASSIST*™ if you are a member of such an insurance plan or if you are applying to Sucraid*ASSIST*™ on behalf of a patient who is a member of such an insurance plan.

Patient Privacy and Consent (read and sign below)
The information you provide will be used by QOL Medical, LLC, Sucraid*ASSIST*™, and parties acting on their behalf to determine eligibility, to manage and improve QOL Medical's assistance programs, to communicate with you about your experience with QOL Medical's assistance programs, to help you understand your insurance coverage and to help you access Sucraid® through your insurance, and/or to send you materials and other helpful information and updates relating to QOL Medical programs. By signing below, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge.

I understand that:

- Completing this application does not guarantee that I will qualify for QOL Medical assistance programs.
- QOL Medical may contact my insurer to help me understand my insurance coverage for Sucraid® and may provide me support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available).
- QOL Medical may verify the accuracy of the information I have provided and may ask for more financial and insurance documentation.
- Any medicines supplied by QOL Medical's assistance programs shall not be sold, traded, bartered, or transferred.
- QOL Medical reserves the right to change or cancel QOL Medical's assistance programs, or terminate my enrollment, at any time.
- The support provided through this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by QOL Medical through the QOL Medical Patient Assistance Program:

- I will promptly contact the QOL Medical Patient Assistance Program if my financial status or insurance coverage changes.
- I will not seek to have this medicine or any cost from it counted in my Medicare Part D true out-of-pocket expenses (TrOOP) for prescription drugs.
- I will not seek reimbursement or credit for the medicine(s) from my insurance prescription provider or payor, including Medicare Part D plans.
- I will notify my insurance provider of the receipt of any medications through the QOL Medical Patient Assistance Program.
- I have a signed copy of a current and completed HIPAA authorization form on record with my prescriber so that my prescriber may share health information about me with QOL Medical's assistance program.
- I agree to be available to sign for delivery of the Sucraid® (sacrosidase) Oral Solution shipment.

Patient First Name: | Last Name:

Patient Signature (or Caregiver): | Date:

Phone: | Email:

Relationship to Patient: