Patient Assistance Program Form

Trogarzo®
(ibalizumab-uiyk)
Injection
200 mg/1.33 mL (150 mg/mL)

INSTRUCTIONS

How to Apply

1) Please verify that your physician has completed the **TROGARZO® Enrollment Form**.
2) Complete and sign page 2 of this form.
3) Attach a copy of your most recent federal tax return.
   - If you do not file a Federal tax return, please attach other proof of yearly household income (such as W-2, 1099, unemployment award letter, social security, disability or pension statement) for everyone living with you.
   - If you have no income, you must attach a letter from the physician or social worker on company letterhead attesting to the best of their knowledge you have no income.
4) Mail this form **and** a copy of proof of income to:
   THERA Patient Support® program
   ASPN Pharmacies, LLC
   290 West Mount Pleasant Avenue, Building 2, 4th floor, Suite 4210
   Livingston, NJ, 07039.

   OR

   Fax this form **and** a copy of proof of income to: 1-855-836-3069

Who Can Enroll (Program Eligibility)

- Patient must be a legal resident of the United States.
- Patient cannot have any private or government drug coverage for Trogarzo®.

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1. Patient Information

First Name _____ Date of Birth _____ MM/DD/YY Gender ☐ M ☐ F

Last Name _____ Marital Status ☐ Single ☐ Married ☐ Widowed

Address _____ Telephone _____

City _____ State _____ Email _____

Zip _____ SSN _____ I am a resident of the U.S. ☐ Yes ☐ No

Patient Representative For Purposes of Program (if applicable)

☐ I authorize the THERA Patient Support® program to speak and write to the following person(s) about this form, and I authorize the person(s) to sign any documents related to the Program on my behalf:

First Name _____ Relationship to Patient _____

Last Name _____ Telephone _____

2. Financial Information

Total Household Income $ _____ Total Household Size _____

Please be sure to attach any of the following:

- Most recent income tax return
- Annual Social Security payment letter
- Monthly pay stub (within the last two months)
- Bank statement showing automatic deposits for the last 2 months

3. Insurance Information

Do you have public or private insurance? ☐ Yes ☐ No

If yes, please provide the following information, and provide a copy of the **front** and **back** of your insurance card:

Name of Insurance Company _____

ID # _____ Policy # _____ Telephone _____

Do you have Medicaid/Medicare? ☐ Yes ☐ No

Are you Medicare Part D enrolled or eligible? ☐ Yes, enrolled ☐ Yes, eligible ☐ No

Do you have other State/Government funded coverage (ADAP, SPAP)? ☐ Yes ☐ No

I attest that the above information is complete and accurate. I attest that I have no or insufficient prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. I understand and agree that PAP medication received will not count toward my true-out-of-pocket costs (TROOP) as defined under the Medicare Modernization Act. I understand that the PAP medication will be shipped to my physician for my pick-up or will be shipped to my home and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the PAP medication to any third party, including my Medicare Part D Plan. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient or Legal Guardian Signature _____ Date _____ MM/DD/YY

US-TRO-2300009

THERA patient support®