Medac Pharma
Patient Assistance Program Application

CORE CONNECTIONS
Coverage, Resources and Education

Application Instructions

Patients wishing to be considered for eligibility must submit a completed application along with:

❑ Original valid prescription(s) with physician signature ❑ Any other applicable documentation

Only faxes sent from the prescribing physician's office along with a physician fax cover sheet and fax banner can be accepted.

Section 1. Financial Information:
All information must be completed.

Section 2. Insurance Information & Patient Signature:
All patient information must be completed. All fields are required. Patients must complete this section.
*Medications available on the program may change from time to time.
*Program reauthorization is required every six (6) months, up to 5 refills per application.
*If the patient has applied for the Medicare Part D Low Income Subsidy through the Social Security Administration within the past year and has been denied, please attach a copy of the denial letter

Section 3. Patient Information:

Section 4. Prescriber Information: Original Patient signature is required for eligibility determination.

Financial Information: List All Sources (Gross Monthly Amounts)

Salary/Wages: $_____ Other (disability, retirement/social security: $ _____

Number of Dependents in Household (including self) _____

Insurance Information (Include front and back copy of insurance card, if applicable)

Private Prescription Drug Coverage?
❑ Yes ❑ No

Medicare? ❑ Yes ❑ No

Medicaid? ❑ Yes ❑ No

Do you have VA Benefits?
❑ Yes ❑ No

Have you received a denial letter for Low Income Subsidy application?
❑ Yes ❑ No
If yes; please attach a copy with your application.

Elderly State Drug Assistance?
❑ Yes ❑ No

I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Medac Pharma, and companies working with Medac Pharma, which may be branded as Medac Pharma™ (collectively, "CORE Connections"), my contact information, health information relating to my medical condition to the extent necessary to support treatment that may also include identifying any potential drug interactions evaluation and allergies, and insurance coverage for Medac Pharma to (i) provide me with support services (which may be branded as CORE Connections™) and related information and materials on any of Medac Pharma products, including, but not limited to, educational support provided in-person, online or by telephone, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided, and (iii) provide me with information about Medac Pharma products, services, and programs and other topics of interest for marketing, educational or other purposes. Once my health information has been disclosed to Medac Pharma, I understand that Federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Medac Pharma. However, Medac Pharma agrees to protect my health information by using and disclosing it only for purposes authorized in this Patient Authorization and Consent or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Medac Pharma in exchange for sharing information concerning any services that the pharmacy may provide to me. I understand that I may refuse to sign this Authorization, and I further understand that my treatment (including with a Medac Pharma product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign this Authorization, or later cancel it, I will not be able to receive any support services from Medac Pharma including those branded as CORE Connections. I may cancel this Authorization at any time by mailing a letter to: Medac Pharma. Canceling this Authorization will end my consent to further disclose health information to Medac Pharma by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Authorization expires December 31, 2028 or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I have read, understand, and agree to the terms in section I above, Authorization to Share Health Information. I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I understand that completing this application form is not a guarantee of eligibility for the CORE Connections Patient Assistance Program. I also understand that Medac Pharma may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare Part D plan, I cannot utilize my Part D plan benefits for products received through the CORE Connections Patient Assistance Program for the duration of my enrollment. Any medication I receive through the CORE Connections Patient Assistance Program will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D.

_____ _____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative | Date

_____

Description of Personal Representative's Authority to Sign for Patient (Attach documents which show authority)

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Patient Information

*First Name: _____ MI: _____ *Last Name: _____ Sex: ❑M ❑F

Email: _____ Last 4 SSN: _____ *DOB: _____

*Mobile Phone: _____ Alt. Phone: _____ *Preferred : ❑Mobile ❑ Alt. Phone ❑ Text ❑ Email

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

* Allergies: _____ *Other Medications: _____

❑M06.9 Rheumatoid arthritis, unspecified ❑ M 08.00 Unspecified JRA ❑L40.9 Psoriasis, unspecified

*Other Diagnosis Code: _____ ❑ Medication List Attached *Prior Oral Methotrexate?: _____

Prescriber Information

*Physician Name: _____ *NPI #: _____ State License #: _____

Practice Name: _____

*Office Phone: _____ Alt.Phone: _____ Fax: _____ Email: _____

Preferred Communication: ❑Office ❑ Alt. Phone ❑ Fax ❑ Email Best Time to Contact: ❑ Morning ❑ Afternoon ❑ Evening

Address: _____

City: _____ State: _____ Zip: _____

Office Contact Name: _____ Contact Phone: _____

Prescribing Information: NY Prescribers – Please Submit Prescription on an Original NY State Prescription Blank

Medication	Strength	Directions	Quantity/Refills
Rasuvo (Methotrexate Inj. SC)	❑7.5mg ❑10 mg ❑12.5mg ❑15 mg ❑17.5 mg ❑20 mg ❑22.5 mg ❑25 mg ❑30 mg	Inject every week as directed ❑ Rasuvo is shipped directly to the patient. Check here to have the product shipped to the Provider's office.	_____Qty _____Refills

I certify that this therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the physician that has prescribed Rasuvo® to the previously identified patient. I authorize PharmaCord on behalf of my patient to facilitate processes to assist the patient in obtaining Rasuvo® as indicated on this prescription. I understand that this medication is being provided free to the named patient by Medac Pharma and agree that no insurer or any government healthcare program may be billed for the cost of this medication.

Physician Signature: _____ Date: _____

Original Signature of prescriber ❑ Dispense as Written Invalid without date

Fax a completed form to (800) 481-3325
PharmaCord Pharmacy NABP: 1836191 NPI: 1699202838

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