EAGLE CAN PATIENT ASSISTANCE PROGRAM FORM

EAGLE CAN
Care & Access Network

Fax completed form to 1-833-324-5346.
If you have any questions, please contact EAGLE CAN®
at 1-833-324-5322, Monday through Friday, 9:00 am – 5:00 pm EST

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eaglecanus.com

Eagle Pharmaceuticals, Inc. ("Eagle") offers a patient assistance program (the "EAGLE CAN Program") to assist qualifying patients in obtaining certain Eagle medications at no cost.

This enrollment form is for patients who have been prescribed one of the following Eagle medications and would like to apply to receive the medication free of charge through the EAGLE CAN Program.
Please select which medication has been prescribed:

☐ **BELRAPZO®** (bendamustine hydrochloride injection) ☐ **PEMFEXY®** (pemetrexed injection)

To qualify, patients must meet ALL the requirements listed below:

- ✓ You have been prescribed an Eagle medication listed above.
- ✓ You are a permanent legal resident of the United States or Puerto Rico.
- ✓ You have no insurance OR your insurance does not cover the prescribed Eagle medication. If you have insurance that does not cover the medication, you must submit documentation that your insurance has denied the claim. Your healthcare provider (HCP) may be able to assist you with obtaining this documentation. If your HCP needs assistance with obtaining the documentation they may contact the EAGLE CAN Program at 1-833-EAGLECAN (1-833-324-5322).
- ✓ You have been prescribed the applicable Eagle medication for an FDA-approved indication.
- ✓ Your Annual Adjusted Gross Household Income must be at or below 500% of the current Federal Poverty Guidelines as determined by your location and number of persons in your household.
  Visit https://aspe.hhs.gov/poverty-guidelines for information on the Federal Poverty Guidelines.

Completing this form is the first step in the application process. The EAGLE CAN Program may need additional information to confirm patient eligibility.

Patient Checklist

Page 2

☐ Complete section 1 – Patient Section

Page 3

› Read section 2 – Patient Agreement and Consent

☐ **Sign, date, and agree to Patient Agreement and Consent at end of section 2**

Provider Checklist

Page 4

☐ Complete section 3 – Prescription/Medication Order Information

☐ **Manually sign and date at end of section 3**

Page 5

☐ Complete section 4 – Healthcare Provider/ Prescriber Information

› Read section 5 – Healthcare Provider/Prescriber Acknowledgment

☐ **Complete, sign and date end of section 5**

Fax the completed application and any supporting documents to the EAGLE CAN Program at 1-833-EAGLE-GO (1-833-324-5346). We recommend that you return the completed form by fax in order to speed up the process Incomplete or incorrect information will delay the process, so please make sure all information is provided correctly and signatures are obtained.

MLR-ONC-US-0043

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ALL FIELDS ARE REQUIRED

1 – PATIENT SECTION

First Name	Middle Initial	Last Name

Address

City	State	ZIP

Date of Birth (MM/DD/YYYY)

Home Phone	Cell Phone

Patient Insurance and Income Information

Adjusted Gross Yearly Household Income	Number of People in Household

Do you have Insurance? Check all that apply

- ☐ Medicaid
- ☐ Medicare A or B
- ☐ Medicare Part D
- ☐ Other: _____
- ☐ VA or Military
- ☐ Private Insurance
- ☐ None

Optional Authorization to Speak With Authorized Representative

If you would like to provide the name of an individual whom you authorize to speak on your behalf with the EAGLE CAN Program Representatives (defined below) about this application, or your participation in the EAGLE CAN Program, please identify the individual below.

An authorized representative has the authority to interact with Program Representatives on an applicant's behalf with respect to the EAGLE CAN application and program, and can provide or receive personal information about the applicant as necessary until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

By providing the name below, I certify that the individual is aware and has consented to my disclosure of their name to Program Representatives for the purpose of serving as my authorized representative:

Name of Authorized Representative: _____

You can remove Authorized Representative at any time by calling 1-833-EAGLE-CAN (1-833-324-5322).

Please see Patient Agreement and Consent on the next page.

2 – PATIENT AGREEMENT AND CONSENT

PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL THE EAGLE CAN PROGRAM AT 1-833-EAGLE-CAN (1-833-324-5322). YOU CAN ALSO TALK TO YOUR DOCTOR'S OFFICE.

- The EAGLE CAN Program offers a patient assistance program to help qualifying patients obtain certain Eagle medications at no cost.
- I understand that I am, or my doctor's office is, submitting this application to see if I qualify for assistance with my Eagle medications through the EAGLE CAN Program. I understand that before I can receive assistance through the EAGLE CAN Program, Eagle may need to collect, use, and share information about me. This information is requested in this application. This information is called My Personal Information. It includes the following:
  - My Health Information ("HI")
  - My financial information
  - Other personal information about me
- My HI may include:
  - Any information related to my healthcare insurance or plan benefits, including coverage limits.
  - Other information related to my health and treatment. This may include information that may be sensitive, relating to sexually transmitted diseases, mental health conditions, and/or genetic testing.
  - Information related to my health while I am in the EAGLE CAN Program, such as whether I'm staying on my medication or treatment.
  - Some information that may not be related to my Eagle medication and is not requested on this form. This information may be sent only because it is part of my health care records.
- Eagle Pharmaceuticals, Inc. and its authorized third-party agents will use my date of birth and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. Eagle Pharmaceuticals, Inc. and its authorized third- party agents reserve the right to ask for additional documents and information at any time.
- I understand that by signing this form, I am permitting the following providers to release My Personal Information, including my Health Information, to the EAGLE CAN Program (defined below):
  - My doctor's office
  - My healthcare plan or insurance company
  - My pharmacies
  - Other providers
- EAGLE CAN "Program Representatives" include Eagle Pharmaceuticals, Inc. and its vendors, business partners, and agents who may be assisting in the operations of the EAGLE CAN Program. I understand that to provide the services for the EAGLE CAN Program, the Program Representatives may need to share My Personal Information with other Program Representatives involved with the EAGLE CAN Program, and with my doctor's office or other healthcare providers, including my insurance company or health plan or pharmacies.
- I further understand that the Program Representatives will use My Personal Information in the following manner:
  - To review my application for the EAGLE CAN Program.
  - To contact me or my doctor's office or other of my healthcare providers, as necessary, to conduct such services.
  - For purposes relating to the operation and administration of the EAGLE CAN Program, including measuring and tracking the quality of the services.
  - To keep track of my use of the medications provided through the EAGLE CAN Program.
- I also understand that the Program Representatives can contact me to collect any additional information needed to provide these services to me or to provide me with important information about the medications provided through the EAGLE CAN Program.
- I understand if I do not sign or refuse to sign this form, I will not be eligible for the EAGLE CAN Program.
- I understand that Eagle may discontinue the EAGLE CAN Program, or my participation in it, at any time and for any reason.
- This authorization allows those who rely on it to release my HI for 1 year from the date I have signed it. I understand that I can withdraw it at any time by sending a written notice to the EAGLE CAN Program by mail to P.O. Box 220126 Charlotte, NC 28222 or by fax to 1-833-EAGLE-GO (1-833-324-5346). My withdrawal goes into effect once it is received by Eagle. I also understand that by withdrawing, I may not receive or I may stop receiving Eagle medications provided through the EAGLE CAN Program.
- I certify that all of the documents I provide for Eagle to determine my eligibility for participation in the EAGLE CAN Program are true, correct, and accurate. If I believe that I no longer meet the criteria for the EAGLE CAN program, I agree to immediately notify Eagle for a re-determination.

I understand that I must annually submit equivalent documentation to determine my continued eligibility for participation in the EAGLE CAN Program through the EAGLE CAN Program. Upon request, Eagle will provide me with the name and address of the consumer reporting agency that provides the credit information. I may call EAGLE CAN at 1-833-EAGLE-CAN (1-833-324-5322) for this information.

☐ **I have read and understand**

Patient or Legal Guardian Signature	Date (MM/DD/YYYY)
Printed Name of Patient or Legal Guardian	

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3 – PRESCRIPTION/ MEDICATION ORDER INFORMATION

Treatment Setting

☐ Healthcare Provider/Prescriber's Office ☐ Hospital Outpatient

Name and Address of Treatment of Facility		
Date	ICD.10	
Patient's Name		Patient Date of Birth (MM/DD/YYYY)
Patient's Address		
City	State	ZIP
Known Allergies		
Concurrent Medications		
Product Requested ☐ BELRAPZO® (bendamustine hydrochloride injection) ☐ PEMFEXY® (pemetrexed injection)	Vial Size/ Strength	
Please Select ○ Dispense as written ○ May substitute		
Directions for Use		# of Vials/ # of Refills
Scheduled Administration Dates	Dosing Schedule/ Frequency	

Provider/ Prescriber Signature	Date (MM/DD/YYYY)

Prescriber Signature (no stamps): I certify that I am the healthcare professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically appropriate, and that the information provided is accurate to the best of my knowledge. I authorize the EAGLE CAN Program Representatives to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy, if applicable.

Your state may require that prescriptions follow certain content requirements or use a particular form. By signing below, you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the state in which you are prescribing.

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4 – HEALTHCARE PROVIDER/ PRESCRIBER INFORMATION

Facility Name		Facility NPI
Healthcare Provider/ Prescriber Name		
Healthcare Provider/ Prescriber State License		
Collaborating Physician (If Applicable)		
Address		
City	State	ZIP
Office Contact	Office Phone	
Phone Ext.	Fax	

5 – HEALTHCARE PROVIDER/ PRESCRIBER ACKNOWLEDGMENT

By signing the below, I certify:

- The information provided is accurate to the best of my knowledge.
- The therapy is medically necessary. I also represent that I am disclosing this information for treatment purposes as well as other medical information that may be disclosed, including medical records of the patient, to Eagle Pharmaceuticals, Inc. and its vendors, business partners, and agents (the "Program Representatives") for the purpose of assessing whether the patient qualifies for the EAGLE CAN Program through the duration of the patient's therapy. I also certify that the patient is aware and has consented to my disclosure of their information to Program Representatives so that Program Representatives may contact the patient to further enable these services.
- I am licensed, will comply with and abide by my State Practitioner dispensing laws for authorized prescribers in the state in which I am prescribing, receiving, storing, and dispensing the medication identified on this application to the patient listed in this application. I prescribed the medication to this patient based on my independent clinical judgment that treatment with this medication for this patient is medically necessary.
- I have prescribed this patient the Eagle medication for an FDA-approved indication.
- To the best of my knowledge the patient meets the financial, insurance, and residency requirements of the EAGLE CAN program. If I am aware the patient no longer meets the criteria for the program, I agree to immediately notify Eagle.
- I have not received and will not seek reimbursement or payment for all or any part of the benefit received by the patient through the EAGLE CAN Program.
- Any medication provided through the EAGLE CAN Program will not be resold, nor offered for sale, trade or barter, or returned for credit.
- The payor has denied coverage for this treatment.

I understand:

- Eagle may change, terminate, suspend participation, limit enrollment, or recall/ discontinue medications in the program without prior notice.
- I am under no obligation to purchase or prescribe any Eagle drug to participate in this program and I have not received nor will I receive any benefit from any Program Representatives for prescribing an Eagle medication.
- Program Representatives are not responsible for filing any insurance claim.
- The information provided will be subject to potential random reviews.
- If for any reason you receive payment from any third-party insurance, government healthcare, or other aid program for Eagle medications provided for the use of this patient through the EAGLE CAN Program, you will immediately notify the EAGLE CAN program by calling
- 1-833-EAGLE-CAN (1-833-324-5322) to report the payment and to determine the amount to be reimbursed to Eagle so that you are not compensated in an amount greater than you would have received had the patient been enrolled in an insurance program that provides you with the average reimbursement rate for the medication.
- If a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Eagle will bill for the covered product.
- I acknowledge that the medication received is patient specific and may not be used for any other patient. If any product is not administered to the enrolled patient for whom it was supplied, I will return the product to Eagle or appropriately destroy the product and submit documentation to Eagle confirming that the product has been appropriately destroyed. If I do not return or destroy the product provided and not used for the applicable enrolled patient, I will be billed for the product and I agree to be responsible for payment of the bill. Please contact the EAGLE CAN Program at 1-833-EAGLE-CAN (1-833-324-5322) for assistance with product returns.

Patient Name	Date of Birth (MM/DD/YYYY)
Healthcare Provider/Prescriber Signature (no stamps)	Date (MM/DD/YYYY)