781 Chestnut Ridge Road Morgantown, WV 26505
Phone: 1.800.796.9526 Fax: 1.877.427.7290
Email: MylanPAP@mylan.com

Mylan Oncology
Patient Assistance Program (MOPAP)

Please print clearly in blue or black ink

(SECTION 1) PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE

First Name: MI: Last Name: Date of Birth:

Mailing Address: Apt #.

City: State: Zip Code:

Social Security Number: Gender Male/Female: Preferred Daytime Telephone:

(SECTION 2) PATIENT ELIGIBILITY INFORMATION

ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME & LACK OF APPLICABLE INSURANCE VERIFICATION (REQUIRED)

GROSS ANNUAL HOUSEHOLD INCOME (Including all Income, Wages, Social Security, Pension, Disability, Unemployment Benefits, Financial Assistance, etc.)

Does the patient meet the income requirements of gross yearly household income below 500% of the current Federal Poverty Guidelines? Yes ❒ No ❒

If "No", the patient is not eligible.

Number of people in household: _____ $_____ Monthly $_____ Annual

LACK OF APPLICABLE PRESCRIPTION DRUG COVERAGE

Is the patient currently enrolled in any state or federal prescription coverage including, without limitation, Medicare, Medicaid, or TriCare? Yes ❒ No ❒

Does the patient have any commercial prescription insurance coverage? Yes ❒ No ❒

If yes, does the commercial prescription insurance only cover generic drugs? Yes ❒ No ❒

IS THE PATIENT RESIDING IN THE UNITED STATES? Yes ❒ No ❒

(SECTION 3) PATIENT AUTHORIZATION FOR INFORMATION USE AND DISCLOSURE

I request and authorize my healthcare professionals and health insurers to disclose to Mylan Specialty, Mylan Institutional Inc., Mylan Pharmaceuticals Inc., and their affiliated companies (collectively, "Mylan") my "Protected Health Information" ("PHI"), as this term is defined under the Health Insurance Portability and Accountability Act of 1996 and its various implementing regulations, as amended ("HIPAA"), so that Mylan may use the information to determine my eligibility for insurance coverage for Oncology Products and to administer my participation in the Mylan Oncology Patient Assistance Program ("MOPAP"). I understand that once disclosed pursuant to this Authorization, my PHI may no longer be protected by federal law and could be re-disclosed to others, but I also understand that Mylan intends to safeguard my PHI and to use and disclose it only for the purposes described herein. I understand that I do not need to sign this Authorization in order to receive healthcare treatment or insurance benefits, and that I may cancel this Authorization at any time by sending a written notice of cancellation by mail to MOPAP Opt-Out Administrator, 781 Chestnut Ridge Road, Morgantown, WV 26505, or by fax to 1-877-427-7290. If I do not cancel it, this Authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this Authorization when it is signed.

_____ _____ _____
[Name of Patient] [Signature] [Date]

_____ _____ _____
[Name of legal representative] [Signature] [Date]

If signed by Representative, describe the nature of relationship with patient: _____

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(SECTION 4) PATIENT CERTIFICATION

I certify that the information detailed on this application is complete and accurate. As noted above, I attest that either: (a) I have no prescription insurance coverage, including, without limitation, coverage through Medicaid, Medicare (including Parts A and B, Medicare Advantage, or Part D), TriCare, a qualified health plan purchased on a state-based partnership, or federally-facilitated Exchange, or any other public or private program or insurer; or (b) I have commercial prescription drug coverage only for generic products and I do not have coverage through any state or federally funded program including, without limitation, Medicare (including Parts A and B, Medicare Advantage, or Part D), Medicaid, or TriCare. I attest that I have insufficient financial resources to afford the prescribed medication, and I meet the MOPAP income eligibility criteria. Additionally, I agree that at any time during my enrollment, the MOPAP may request additional documentation to validate the statements made on my application. I certify that I will not resell, trade or barter, or return for credit, any product received from the MOPAP, nor will I submit to an insurance claim or other claim for payment to any third party for any product received from the MOPAP. I understand and acknowledge that MOPAP assistance may be temporary and that this program may be changed or discontinued at any time without notice.

_____	_____	_____
[Name of Patient]	[Signature]	[Date]
_____	_____	_____
[Name of legal representative	[Signature]	[Date]

If signed by Representative, describe the nature of relationship with patient: _____

(SECTION 5) PHYSICIAN INFORMATION

TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	MI:	Last Name:	Professional Designation:
State License #:		Facility Name:	
Shipping Address: (Cannot be shipped to the patient or P.O. Box)			
City:		State:	Zip Code:
Contact Name:		Telephone Number:	Fax Number:
		( )	( )

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(SECTION 6) PRESCRIPTION INFORMATION AND PHYSICIAN CERTIFICATION

PLEASE ATTACH A COPY OF THE PATIENT'S PRESCRIPTION

- ❒ Fulphila® 6mg/0.6mL PFS Quantity _____
- ❒ Ogivri® 150mg LYO Quantity _____
- ❒ Ogivri® 420mg LYO Quantity _____

I certify that I have prescribed the Mylan Oncology Product(s) described above for the patient identified in Section 1 and that this medication is medically necessary for the patient. I certify that all information I have provided about this patient is complete and accurate, and I understand that the MOPAP and/or its agents are relying on this information to determine patient eligibility. To the best of my knowledge, the patient either (a) has no prescription insurance coverage, including, without limitation, coverage through Medicaid, Medicare (including Parts A and B, Medicare Advantage, or Part D), TriCare, a qualified health plan purchased on a state-based, partnership, or federally-facilitated Exchange, or any other public or private program or insurer; or (b) has commercial prescription drug coverage only for generic products and does not have coverage through any state or federally funded program including, without limitation, Medicare (including Parts A&B, Medicare Advantage, or Part D), Medicaid, or TriCare. I further certify that the patient has insufficient financial resources and meets the MOPAP income eligibility criteria. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the free product provided by the MOPAP. I understand that MOPAP reserves the right to modify or terminate this program at any time. By signing below, I certify that the medication received from MOPAP will not be resold or offered for sale, trade or barter, and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by MOPAP, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand MOPAP reserves the right to recall or discontinue product at any time without notice.

Physician Signature: _____ Date:_____

MANDATORY SUBSECTION FOR ALL OHIO BASED PHYSICIANS

Under Ohio law, Mylan Pharmaceuticals Inc., which holds wholesale distributor license number WHS.010013150-03 (expiring June 30, 2021), may only provide prescription drugs to prescriber's whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity, including prescriber practices, to receive, purchase, and possess prescription drugs and controlled substances, for distribution to patients. Not all prescriber practices, however, are required to obtain a TDDD license. For example, subject to certain exceptions, an individual prescriber doing business as a sole proprietor (not incorporated in any manner) or a practice that is a corporation, limited liability company, or professional association where a prescriber is the sole shareholder and is authorized to provide the professional services being offered by the practice are exempt from obtaining a TDDD license. For a complete list of exemptions, please refer to section 4729.541 of the ORC. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at www.pharmacy.ohio.gov/PrescriberTDDD. The above information is being provided for your convenience and is not offered as, nor should it be construed as, legal advice.

Please select and complete one of the following:

- ☐ The practice at which I work, [insert name] _____, located at the address I provided above, has an active TDDD license that allows me to receive and store the requested product at this location. The TDDD license number is _____ and expires on _____.

OR

- ☐ The practice at which I work, [insert name] _____, located at the address I provided above, is subject to one of the TDDD licensing exemptions in ORC § 4729.541.

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested product at the address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

Physician Signature: _____ Date:_____

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(SECTION 7) FINAL CHECKLIST

Before returning this application, please ensure the following have been completed:

❒ Patient or legal representative has completed and signed the application (Sections 1-4)

❒ Physician has completed and signed the Physician Information, Mandatory Subsection for Ohio Based Physicians (if applicable), and Prescription Information and Physician Certification sections (Sections 5 & 6)

❒ A copy of the patient's prescription has been attached (Section 6)

❒ Copies verifying current financial status have been attached (Please do not send original documents)

❒ Copies verifying lack of applicable prescription drug coverage have been attached (Please do not send original documents)