APOKYN®
apomorphine hydrochloride injection

Patient Assistance Program (PAP)

Enrollment Form for Uninsured Patients

Phone: 1-877-727-6596 (Option 3) Fax: 1-888-525-2431
9:00 AM - 6:00 PM Eastern Time Monday - Friday

Required Documentation:

☐ Completed Application Form: Must be completed by the patient or an authorized representative of the patient

Patient Information

Patient Name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Other Phone: _____

Caregiver Name: _____ Phone: _____

Patient Has Insurance: ☐ Yes ☐ No
If yes, a copy of insurance card(s) is required.

Sex: ☐ Male ☐ Female Date of Birth: _____
(MM/DD/YY)

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Is patient a US resident: ☐ Yes ☐ No

Total Annual Household Income: $ _____

Total number of people in household dependent upon income provided (including patient): ☐

Annual Household Income — Money earned by all persons associated with an U.S. Individual Income Tax Return.

Household Size — Number of persons associated with the Annual Household Income and/or who are claimed on an U.S. Individual Income Tax Return.

Prescriber Information and Shipping Address

Facility Name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ ZIP: _____
(For Shipping [No PO Boxes])

Facility Phone: _____ Facility Fax: _____

Prescriber Name: _____

City: _____ State: _____ ZIP: _____

Office Contact Name and Title: _____

_____

Contact Phone: _____

Contact Email: _____

PATIENT DECLARATION

In connection with my application for the US WorldMeds LLC ("USWM") Patient Assistance Program (PAP) for APOKYN, I authorize USWM and its third-party administrators to use this information provided in this application to determine my eligibility for participation in the Patient Assistance Program for APOKYN. I further understand that once my health information is released to USWM, it may not be protected by federal health privacy laws. This authorization will remain in effect until I no longer need assistance from the Patient Assistance Program for APOKYN or until I revoke the authorization by calling an Apokyn Patient Program representative at 1-877-7APOKYN (1-877-727-6596) Option 3 or by sending a fax to 1-888-525-2431 stating my revocation. This shall not affect any action taken by USWM in reliance on this authorization before USWM received my written notice of revocation. By signing below, I certify that the information I have provided on the attached PAP enrollment form is true and correct. I also verify that I have no other health insurance prescription coverage for APOKYN including but not limited to Medicare, Medicaid, employer/retiree-sponsored coverage, state pharmacy assistance program (SPAP), and I will not request any payment from any third party for APOKYN.

I understand that USWM sets the criteria for this program and that acceptance into the program now, or at any time, is not a guarantee that I am entitled to receive assistance indefinitely.

By signing below, I attest that the financial and household information I have provided is complete and accurate and that USWM may contact me directly to verify my eligibility and to audit any information provided. I also understand that if my insurance or financial situation changes at anytime during my participation in this PAP, I agree to inform USWM of my changes. Changes in household income/household size and insurance coverage may alter my ability to participate in the PAP. USWM reserves the right to discontinue, modify or change the program at any time.

_____
Patient Name (Printed)

_____ _____ / / _____
Patient Signature Date

If Power of Attorney or other legally authorized signatory signs this declaration on behalf of the patient, documentation providing proof of said legal agreement must also be submitted along with this declaration.

US WorldMeds