RADIUSASSIST™

Patient Assistance Program

PROGRAM APPLICATION

PATIENT ELIGIBILITY CRITERIA:

Medicare Beneficiary	Commercially-Insured but Not Covered	Uninsured
• Patient must have an FDA-approved, on-label diagnosis for TYMLOS® (abaloparatide) injection • Patient must have an Annual Household Income <300% Federal Poverty Level (FPL)* • Patient must be a legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico • Patient must not be enrolled in Medicaid, Tricare, Veterans Health Administration, or Indian Health Service benefit programs • Patient must not be enrolled in full Low-Income Subsidy (LIS)† from the Social Security Administration • Patient must not be eligible for State Pharmacy Assistance Programs in which TYMLOS participates	• Patient must have an FDA-approved, on-label diagnosis for TYMLOS® (abaloparatide) injection • Patient must have an Annual Household Income <300% Federal Poverty Level (FPL)* • Patient must be a legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico • Patient must not be enrolled in Medicaid, Tricare, Veterans Health Administration, or Indian Health Service benefit programs • Patient must have neither insurance coverage for nor access to other coverage for TYMLOS	• Patient must have an FDA-approved, on-label diagnosis for TYMLOS® (abaloparatide) injection • Patient must have an Annual Household Income <300% Federal Poverty Level (FPL)* • Patient must be a legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico • Patient must not be enrolled in a Medicare or commercial prescription drug plan or Medicaid, Tricare, Veterans Health Administration, or Indian Health Service benefit programs

*Find current U.S. Federal Poverty Guidelines online at www.aspe.hhs.gov/poverty-guidelines

†To apply for LIS, please contact the Social Security Administration at (800) 772-1213 (TTY 800-325-0778) or go to https://secure.ssa.gov/i1020/start

INSTRUCTIONS:

1. Complete all fields to ensure application can be processed
2. Make sure the application is signed and dated by the prescriber
3. Make sure the application is signed and dated by the patient
4. Include all Required Documentation (see below)
5. Send completed application and required documents:

   Fax to 1-800-910-4610 or Mail to

   Radius Assist Patient Assistance Program (PAP)
   6000 Park Lane Drive
   Pittsburgh, PA 15275

ADDITIONAL INFORMATION:

- Patients and prescribers will be notified by phone or mail of the approval or denial of the application
- Please allow up to 4 weeks for application processing
- Approved patients may receive up to a 3-month supply of medication at a time, for up to 12 months, subject to continued eligibility and pursuant to a valid prescription
- Questions? Patients and prescribers may call Radius Assist at 1-866-896-5674

REQUIRED DOCUMENTATION:

Patients	Prescribers
• Sections 1 through 5 completed in their entirety (page 2) • Section 4 signed and dated (hard copy/wet signature required) • Copy of insurance card(s) and pharmacy benefits card(s) (front and back) • Copy of most recent proof of income (e.g., Form 1040, Form 1099, Form SSA 1099, etc.) • A signed and notarized Power of Attorney (POA) for signatures other than the patient's original signature	• Sections 6 and 7 completed in their entirety (page 3) • Section 7 signed and dated (hard copy/wet signature required) • For commercially-insured patients, a copy of prior authorization and appeal denial(s) must be submitted **DO NOT INCLUDE PATIENT MEDICAL RECORDS**

1. PATIENT INFORMATION

Patient Name *(Last):* _____ *(First):* _____

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

☐ Female ☐ Male ☐ Prefer not to answer Date of Birth: _____

Best Phone Number to Contact You: _____ Social Security Number: *(For income verification)* _____

Are you a permanent, legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico? ☐ Yes ☐ No

2. PATIENT INSURANCE INFORMATION

Do you have insurance? (Check all that apply.)

☐ Medicaid
☐ Medicare Part D Plan
☐ None
☐ Veterans Health Administration
☐ Full low income subsidy (LIS/"Extra Help")
☐ State Pharmacy Assistance Program
☐ Tricare
☐ Indian Health Service
☐ Other: _____

Have you included a copy of your insurance card(s) and pharmacy benefit card(s) *(front and back)*? ☐ Yes ☐ No

3. PATIENT HOUSEHOLD INCOME INFORMATION

Current Annual Household Income: $ _____

Number of Persons in Household *(including yourself, spouse, and dependents)* : _____

Have you included proof of income documentation? ☐ Yes ☐ No

Send at least 1 document that shows your income, such as last year's Federal Income Tax return or Social Security statement. Patients who only receive Social Security may submit a Social Security statement provided there were no other sources of income during the calendar year (subject to program verification).

4. PATIENT CERTIFICATION

PATIENT DECLARATION:

I CERTIFY: (1) I do not have the ability to pay for the medication(s) requested by my healthcare provider on the attached prescription(s). (2) I will notify Radius Assist within thirty (30) days if my financial status or health insurance coverage changes. (3) I will not sell, trade, or distribute any products given to me via Radius Assist. (4) I will verify my PAP application status and receipt of the indicated medication(s) upon request by Radius Assist. (5) If I receive free product through Radius Assist, I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program, including Medicare and Medicaid. (6) If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my True Out-of-Pocket (TrOOP) cost for prescription drugs. (7) All of the information provided in this application, including household income and insurance, is complete and accurate.

I UNDERSTAND AND AGREE: (1) That program assistance will terminate if the PAP becomes aware of any fraud or if this medication is no longer prescribed for me. (2) That completing this application does not ensure that I will qualify for patient assistance, and that my eligibility to participate in Radius Assist is subject to the decision of Radius. (3) That I may be required to provide proof of ineligibility for certain other prescription coverage programs in order to meet the eligibility requirements for the PAP. (4) That Radius Assist reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. (5) That I may choose to opt out of Radius Assist at any time by notifying a representative at 1-866-896-5674 or by notifying the program in writing at the address listed above. (6) I authorize Radius Assist and its administrator to forward this prescription to a dispensing pharmacy on my behalf.

Patient's or Patient Representative's Signature: X _____ **Date:** _____

5. PATIENT AUTHORIZATION

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION: I authorize my healthcare providers, my health plan, and insurers to give health and other information about my use or need for medications provided under Radius Assist to third-party Radius vendors in charge of administering the PAP. My health and other information are referred to below as "Information." I authorize Radius Assist, Radius, their agents, and thirdparty contractors or their service providers to further use and disclose my Information in connection with the PAP. I understand: (1) That my Information will include my name, address, Social Security number, income, prescription coverage, prescription for medication(s), financial documents, insurance records, and any other information provided on this form. (2) That people with the PAP, Radius, or others working on behalf of the PAP may see and use my Information for administering the PAP. (3) That my Information may be used to see if I meet the eligibility requirements to participate in the PAP, to obtain a credit report to help estimate my income as part of the eligibility determination process, to help me enroll in the PAP (if I am eligible), to find out whether I may be eligible for, or am already enrolled in, another program (including an insurance plan or other charitable program), to ship appropriate medication(s), and to contact me to seek feedback on Radius Assist services. (4) That I will be notified by the PAP if I do not meet the requirements to participate in the PAP.

WITHOUT LIMITING THE PURPOSES FOR THE DISCLOSURE OF INFORMATION SET FORTH ABOVE, I UNDERSTAND: (1) That the PAP, Radius, their agents, and third party contractors or service providers will keep my Information private, but that federal privacy laws may no longer protect my Information once it is disclosed, and that my information may be legally re-disclosed by recipients if not prohibited by state law. (2) That this authorization will expire 1 year from the date this form is signed unless I cancel it in writing. (3) That I may cancel this authorization at any time by giving written notice to Radius at the address on this form, but my cancellation will not change any actions taken with my Information prior to cancelling, and my enrollment in the PAP will end. (4) That I have the right to receive a copy of this authorization from my healthcare provider and/or Radius, and that I may inspect/obtain a copy of the information disclosed pursuant to this authorization. (5) That I can refuse to sign this form, and that if I refuse to sign, it will not change the way that my healthcare providers, health plans, and insurers treat me. (6) That if I do not sign this form, I will not be able to participate in the PAP.

Patient's or Patient Representative's Signature: X _____ **Date:** _____

6. PRESCRIBER INFORMATION

Prescriber Name *(Last):* _____ *(First):* _____

Practice Name: _____

Practice Street Address: _____ City: _____ State: _____ Zip: _____

NPI Number: _____ **Office Contact Name:** _____

Best Phone Number to Contact You: _____ Fax Number: _____

7. PRESCRIPTION AND PRESCRIBER CERTIFICATION

Patient Name *(Last):* _____ *(First):* _____ Date of Birth: _____

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

Medication Name: TYMLOS® (abaloparatide) injection 80 mcg **Directions:** Daily, subcutaneous 80 mcg injection

Quantity: ☐ 4.68 mL (90 days) **Refills:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ PRN ☐

Has patient previously been on TYMLOS? ☐ Yes ☐ o If Yes, for how many months? ☐

Pertinent Medical History: _____

Concurrent Medications: _____

Allergies: _____

What is the patient's diagnosis? ☐ M80.__ **osteoporosis with current pathological fracture**

☐ M81.__ **osteoporosis without current pathological fracture**

Ancillary Supplies: One-hundred pen needles (100 days) **Refills:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ PRN

By signing this form, **I certify the following**: (1) I am prescribing TYMLOS® (abaloparatide) for the patient identified on this form based on my independent clinical judgment, and that this prescription medication is medically indicated for the patient and that it will be used as directed; (2) I have authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (3) my license is active and in good standing with my state medical board and I am not debarred by any local, state, or federal entities; (4) to the best of my knowledge, the patient identified on this form does not have prescription drug insurance coverage under (a) Medicaid, Tricare, Indian Health Service, or Veterans Health Administration benefit programs, (b) if a Medicare beneficiary, has applied for and has been denied LIS from the Social Security Administration or has not applied because the patient has an annual household income >150% FPL, and is not eligible for a state pharmacy assistance program in which TYMLOS participates, and (c) if commercially insured, has neither insurance coverage for nor access to other coverage for TYMLOS® (abaloparatide); (5) I will immediately notify the Radius Assist Patient Assistance Program ("Radius Assist" or the "PAP") if I become aware that this patient's insurance or income status has changed; (6) I will be supervising the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge; (7) I will not submit an insurance claim or any other claim for payment for any medication dispensed or administered to the patient through the PAP from insurer, health plan, or government program, including Medicare and Medicaid. I understand that: (1) Radius Assist reserves the right to verify all information provided by any healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment in the PAP based on available resources; (2) Radius Assist reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) Radius Assist, and its agents and assignees, are relying on the certifications in this form.

Original Prescriber Signature: X _____ **Date:** _____

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