# JazzCares for ZEPZELCA™
# Patient Assistance Program Application

Call Toll Free: 1-833-533-5299
Monday-Friday: 8:00 AM to 8:00 PM ET
Fax: 1-855-593-3955
OR Mail: JazzCares Program
6000 Park Lane
Pittsburgh, PA 15275

## How to Apply

1. Please complete the application in its entirety.
2. Please sign the Patient Certification and Authorization section.
3. Please provide a copy of proof of legal U.S. residency, including Puerto Rico and the U.S. Virgin Islands.
4. Please include copies of one or more of the following proofs of income:
   - Copy of your most current Federal Income Tax Form(s) for all earners in your household
   - W2 statements for all earners in your household
   - Yearly benefits statement (SSA, 1099)
   - One month of pay stubs
   - Three months of bank statements showing income deposited and source
   - Unemployment letter or worker's compensation statements
   - Veteran's benefits, alimony/child support, or rental income
   - Employer letter on company letterhead
   - If you have prescription drug insurance, a copy of the front and back of your prescription drug card
   - For those with zero income, a letter from patient/family, person they are living with, or clergy explaining how patient is supported with no income. Letter on facility letterhead from social worker or physician can also be submitted explaining patient's situation.
5. Mail or fax the application, together with the supporting documents, to the address or fax number above.

## Eligibility Requirements

1. You must be a legal U.S. resident, including Puerto Rico and the U.S. Virgin Islands, and have a valid prescription for ZEPZELCA from a physician licensed in the U.S.
2. Your prescription must be for the treatment of relapsed small cell lung cancer.
3. Your total household gross income must be less than 400% of the Federal Poverty Level as defined by Health and Human Services.
4. You must provide proof of income from one or more of the sources listed under "How to Apply."
5. You must have either (a) no insurance coverage, or (b) insurance coverage but deemed uninsured due to lack of coverage for ZEPZELCA.
6. There is no guarantee of approval. The criteria listed above are subject to change at any time in Jazz Pharmaceuticals' sole discretion.

## Patient Information

| | | |
|---|---|---|
| First Name: | MI: | Last Name: |
| Social Security # *(if you do not have an SSN, please provide another form of ID [i.e., Green Card or Work Visa number]):* | | |
| Date of Birth: / / | Gender: ☐Male ☐Female ☐Prefer not to say | |
| Address: | | Apartment/Suite #: |
| City: | State: | Zip Code: |
| Home Phone: | Cell Phone: | |
| Email: | | |
| Language: ☐English ☐Spanish ☐Other: _____ | | |
| Best Time to Contact: ☐Morning ☐Afternoon ☐Evening | | |
| How many people live in your household? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8+ | | |
| Total Annual Household Income of All Earners (including SSI, pension income, etc.) **$** | | |
| Are you a legal resident of the U.S.? ☐Yes ☐No | Do you have private medical insurance? ☐ Yes ☐ No | |
| Do you have government medical insurance? *(Such as: Medicare B/D, Medicaid, Veteran's Administration, State or another government-sponsored program)*: ☐Yes ☐No | | |
| Insurance Company Name: | | |
| Member ID: | Group #: | Insurance Phone: |

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## Patient Certification and Authorization

I attest that the above information is complete and accurate. I attest that I have no or insufficient prescription insurance for the indicated medication, including Medicaid, Medicare, or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. I understand and agree that the PAP medication received will not count toward my true-out-of-pocket costs (TROOP) as defined under the Medicare Modernization Act. I understand that the PAP medication will be dispensed to me by my physician and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the PAP medication to any third party, including my Medicare Part B or Part D Plan. By my signature, I authorize the release of the information about me and my medical condition to Jazz Pharmaceuticals and/or their agents. I authorize Jazz Pharmaceuticals and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment and administration of the Program, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities Jazz Pharmaceuticals may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, Jazz Pharmaceuticals may request additional documentation to authenticate the statements made on my application. Jazz Pharmaceuticals and/or their agents agree to not disclose any information to any third party except those required for program administration as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. The information above will append the incomplete information provided on my original enrollment application.

I hereby authorize my prescriber(s) and their staff and my health insurer(s) to disclose my personal health information (“Personal Health Information” or “PHI”) to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together “Jazz Pharmaceuticals”) for the JazzCares ZEPZELCA Program (the “Program”).

I understand and authorize Jazz Pharmaceuticals to use the PHI it receives as a result of this Authorization for the following purposes: (i) enrolling me in the Program; (ii) verifying, investigating, coordinating and resolving insurance coverage or reimbursement inquiries and payment for ZEPZELCA; (iii) coordinating my receipt of and payment for ZEPZELCA; (iv) contacting me about the Program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my PHI to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (vi) de-identifying my PHI by aggregating it for research purposes, and (vii) managing the Program.

I understand and authorize Jazz Pharmaceuticals to contact me through a variety of means including email, postal mail, phone, or fax, unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below.

I understand Jazz Pharmaceuticals will not disclose my Personal Information to a third-party that is not related to the Program (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my PHI, I understand the receiver may not be subject to HIPAA or other privacy laws and the PHI might be re-disclosed by the recipient and no longer protected by HIPAA or other privacy laws.

I understand I may refuse to sign this Authorization and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s). I also understand that if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand I may revoke this Authorization at any time in the future except to the extent Jazz Pharmaceuticals has already taken action in reliance on this Authorization and my future revocation will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s); but if I revoke this authorization I may no longer be eligible to participate in the Program.

This Authorization will remain valid for five (5) years after the date of my signature unless a shorter time is required by state law. I can also revoke it earlier by calling 1-833-533-5299 or sending my request to JazzCares ZEPZELCA Program, 6000 Park Lane, Pittsburgh, PA 15275. I also understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this Authorization that is on file with Jazz.

I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

**Patient or Legal Guardian’s Original Signature:**

**Date:**

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| Physician Information | | |
|---|---|---|
| Physician Name: | Specialty: | |
| Practice Name: | Office Contact: | |
| NPI: | State License #: | |
| Tax ID: | PTAN: | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |
| Email: | | |
| Setting of Care: ☐ Physician's Office ☐ Outpatient Hospital ☐ Other (explain): | | |
| Is doctor contracted with patient's insurance? ☐ Yes ☐ No | | |

| Shipping Information | | |
|---|---|---|
| Check if same as above: ☐ | | |
| Practice Name: | | |
| Department: | | |
| Shipping Address: | | |
| Corresponding DEA #: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

| Diagnosis & Clinical Information | |
|---|---|
| **Diagnosis (Please indicate ICD-10 Code):** | |
| ICD-10 Description: | |
| **Has this patient been diagnosed with relapsed small cell lung cancer?** ☐ Yes ☐ No | |
| Currently take ZEPZELCA? ☐ Yes ☐ No | Start Date: |

| Treatment Information | | |
|---|---|---|
| **Product Requested** | **Dose** | **Treatment Date(s)** |
| | | |
| Other Drug(s) prescribed with ZEPZELCA: | | |
| CPT Code(s): | | |

## Physician's Signature

By signing below, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to Jazz Pharmaceuticals and its affiliates or vendors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

**Physician's Signature (NO STAMPS PLEASE):**

**Date:**