JazzCares®
Making a difference in Patients' lives, one Patient at a time

Patient Assistance Program Application

Contact the Certified Pharmacy (ESSDS) at 1-866-997-3688, Mon-Fri, 7 AM-8 PM CT.
Fax form to 1-866-470-1744 or mail to the address below.

Medication Select One

*Indicates required field. †Indicates required only if requested by the Certified Pharmacy (ESSDS).

Personal Information (Please print)

*Name _____ *Date of birth ____ / ____ / ____

*Address _____ *City _____ *State _____

*Zip _____ *Phone number _____ Alternate phone _____

Insurance

*Do you have insurance that helps pay for any of your medication? ☐ Yes ☐ No

***If yes**, indicate if insurance is private/commercial plan ☐ or government (eg, Medicare, Medicaid, VA) plan ☐

*Has your employer, insurance company, or another third party (eg, SHARx, Paydhealth, Payer Matrix) directed you to apply to the JazzCares Patient Assistance Program? ☐ Yes ☐ No

Income

*Total number of people in your household (eg, you, spouse, dependent[s]) Adult(s) _____ Dependent(s) _____

*Total annual combined household income $ _____

Medical Expenses

☐ †**Provide the total** of your monthly medical expenses $ _____

☐ †**Attach a copy** of all receipts for your monthly medical expenses

Proof of Income

☐ ***Attach a copy** of last year's Federal Income Tax Returns for all members of your household (ie, you, spouse, dependent[s]) **OR**

☐ ***Attach a copy** of all income statements (W2 or 1099) **OR** Social Security Benefits Statement, **if you did not file** a federal income tax return last year

I understand that to qualify for free medicine under this program, program eligibility criteria must be met, including income verification. I certify that all the information in this application, or information I am requested to provide in connection with this application, including all copies of documents proving my income and medical expenses, are true and accurate to the best of my knowledge. I attest that I am authorized to sign this application. I attest that I have no or insufficient prescription insurance for the indicated medication that is provided by Medicaid, Medicare, or any other public or private program, and I have insufficient financial resources to pay for the prescribed therapy. In addition, I will contact JazzCares if any of my information about my prescription drug coverage or insurance changes.

I understand and agree that the Patient Assistance Application medication that I receive will not count toward my TROOP as defined under the Medicare Modernization Act. I understand that the Patient Assistance Application medication will be dispensed to me by ESSDS and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the Patient Assistance Application medication to any third party, including my Medicare Part D Plan.

Signature of Applicant or Legal Guardian _____ **Date** _____

Mailing Instructions

☐ Attach proof of income and receipts for all medical expenses stated above

☐ Complete, sign, date, and mail application to JazzCares Patient Assistance Program, PO Box 66589, St. Louis, MO 63166-6589

Eligible individuals must be enrolled in the XYWAV and XYREM REMS. Eligible individuals must be a resident of the US, Puerto Rico, or other US territory. Eligible individuals must be prescribed XYWAV or XYREM by a provider licensed and practicing within the US. Jazz Pharmaceuticals, Inc. reserves the right to terminate or modify this program at any time with or without notice. Other terms and conditions apply.

The JazzCares Patient Assistance Program is administered by ESSDS on behalf of Jazz Pharmaceuticals, Inc.

ESSDS=Express Scripts Specialty Distribution Services; FDA=Food and Drug Administration; REMS=Risk Evaluation and Mitigation Strategy; TROOP=true-out-of-pocket costs; VA=US Department of Veterans Affairs.

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Jazz Pharmaceuticals