Serva Health LLC ATTN: CIYC PAP
1000 Bishops Gate Blvd Ste 201
Mount Laurel, NJ 08054

ANI Rare Disease Patient Assistance Program, Inc., Application

- Download the application and fill it out **completely** before submitting.
- If you have any questions, call 1-800-805-5258 (toll free).
  Incomplete applications may cause delays in obtaining assistance.

- There are 3 ways to submit the application:
  - Mail the completed application and supporting materials to:
    Serva Health LLC ATTN: CIYC PAP
    1000 Bishops Gate Blvd Ste 201
    Mount Laurel, NJ 08054
  - Fax form with any other supporting materials to 1-833-477-8839
  - If email is preferred, call 1-800-805-5258 (toll-free) to make the request

1. Patient Information

First Name ____________ MI ________ Last Name ______________ Gender ☐ M ☐ F

Mailing Address ______________________ City __________ State _____ ZIP _____

Home Phone __________ Leave Message? ☐ Y ☐ N Cell Phone __________ Leave Message? ☐ Y ☐ N

Email ______________________ Date of Birth __________ Last four digits SSN _____

2. Prescriber Information

Physician Name ______________________ Physician NPI ______________________

Address ______________________ City __________ State _____ ZIP _____

Primary Phone ______________________ Alternate Phone ______________________

Email ______________________ Fax ______________________

3. Insurance Information

Does the patient have health insurance? ☐ Y ☐ N

☐ If yes, and mailing form, attach a copy of prescription insurance card for all insurers. If not, complete information below for all insurers:

Insurance #1 Name ______________________ Member ID ______________________

Insurance Phone Number ______________________ RxGroup # ______________________

Policyholder's Name ______________________ RxBIN # ______________________

Policyholder's Date of Birth ______________________ RxPCN # ______________________

Insurance #2 Name ______________________ Member ID ______________________

Insurance Phone Number ______________________ RxGroup # ______________________

Policyholder's Name ______________________ RxBIN # ______________________

Policyholder's Date of Birth ______________________ RxPCN # ______________________

Insurance #3 Name ______________________ Member ID ______________________

Insurance Phone Number ______________________ RxGroup # ______________________

Policyholder's Name ______________________ RxBIN # ______________________

Policyholder's Date of Birth ______________________ RxPCN # ______________________

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ani Pharmaceuticals, Inc.

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Does patient participate in any of the following? Check all that apply:

- ☐ Medicare
- ☐ Medicare HMO or Medicare + Choice or Medicare Advantage
- ☐ Medicare Program for Reimbursed Self-Injectable Drugs
- ☐ Medicaid
- ☐ Low Income Subsidy (LIS) program a.k.a. Extra Help
- ☐ Any other federal healthcare program(s), please list: ____________________
- ☐ Veterans Administration Programs
- ☐ Indian Health Service Programs
- ☐ Public Health Service Programs
- ☐ Department of Defense Programs
- ☐ TRICARE/CHAMPUS

4. Financial Information

How many people live in your household? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other

Total annual household income (including salary/wages, social security income, disability income, any other income):* ____________________

*The following supporting documentation or other verification will be required. Acceptable forms of documentation include: federal income tax return or forms for most recent filing year (1040, 1040EZ, 1099, 1099-DIV); yearly benefits statement (SSA, 1099, or awards letter); W-2 for most recent tax year; pay stubs for 1 month of pay within the last 90 days; unemployment letter or workers compensation; and/or Food and Shelter letter from the Medical Doctor Office (MDO) physically signed by someone from the MDO and on office letterhead.

5. Patient Certification

I certify that, as of the date of my signature, the information provided in this application is complete and accurate to the best of my knowledge and that all of the insurance plans and programs through which I obtain health care coverage are listed above or have been provided separately to the ANI Rare Disease Patient Assistance Program ("Program"). I understand that the Program is entitled at any time to request verification of any such information which I agree to provide from me, my insurer, and/or other benefit providers; and, among other things, request such information, verify my application status, and/or confirm my receipt of the drug(s) dispensed through the Program. I authorize ANI Pharmaceuticals, Inc., and its partners or agents (and any agents thereof) to request documentation from me, my employer, my health care provider, or my insurance company and to obtain information from these and other companies, including obtaining credit reports and other information from consumer reporting agencies, credit reporting agencies or data brokers to confirm or verify my financial eligibility. I understand that completion of this application and the provision of the requested documentation does not guarantee I will be approved for the Program and eligibility is subject to the Program's sole discretion. I understand the Program reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program. If eligible to receive assistance, I understand there is no purchase requirement associated with such assistance. Further, any product provided to me at no charge will be provided on a complimentary basis; I will not submit or cause to be submitted any claims for payment or reimbursement to any third-party payer, including a Federal health care program for such product; I will not sell, trade, or distribute or otherwise transfer the Program drugs; and the cost of the product will not count toward any Medicare true out-of-pocket ("TrOOP") costs. If approved, as required by my insurance or other benefit provider, I will notify such provider of my receipt of any drug(s) through the Program. The Program does not cover or provide support for supplies, procedures, or any physician-related services associated with ANI patient therapy. I understand that I must re-apply for the Program annually.

Patient Name (please print): ______________________________ Date:______________

Patient Signature (original signature required): ______________________________ Date:______________

Legal Representative Name (please print): ______________________________

Parent/Guardian/Legal Representative Signature: ______________________________ Date:______________

If signed by a Personal Representative, please describe your authority to act on behalf of the patient:______________________

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