Patient Assistance Program (PAP) Application

Smith+Nephew

Patient Assistance Program

Phone: 833-965-1620 | Fax: 833-965-1621 | M-F, 8AM to 5PM CST

Please complete application in full, sign and date, then fax to: 833-965-1621
Or email to: PatientAssistanceProgram.us@PAP.smith-nephew.com

- The PAP Application must be complete to be reviewed for patient program eligibility. **Please ensure all areas of the form are completed in full, including all signatures.**
  - » Provider to complete all sections in red
  - » Patient to sign section in blue
- To be considered for the Smith+Nephew Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:
  - » Applicants must be fully Uninsured or be covered by Medicaid.
  - » Only uninsured applicants must complete the Financial Information section below and must qualify for the program financial requirements of 138% of FPL or below
  - » **Applicants that are eligible for and/or are enrolled in a Medicare plan or Commercial/Exchange are not eligible for the program.**
  - » Applicants must be permanent United States resident (includes Puerto Rico).
  - » The requested product must be prescribed by a licensed U.S. healthcare professional for a Food and Drug Administration (FDA) approved indication.
  - » Applicants in a skilled/Part A nursing home stay are not eligible for the program.
- Each applicant will be individually assessed for program eligibility based on the information provided within this application.
- Applicants will only be evaluated for eligibility upon receipt of a completed and signed Smith+Nephew Patient Assistance Program (PAP) Application.

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Patient Information:

Name: Date of Birth: Legal US Resident: ☐ Yes ☐ No

Address: City: State: ZIP:

Patient Phone:

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening Gender:

Insurance (Include Copy of Ins. Card): ☐ Medicaid ID: ☐ Uninsured

Insurance Name: Nursing Home Resident? If so, ☐ Skilled ☐ Non-Skilled

Nursing Home Contact Name: Nursing Home Contact Phone #:

Prescriber Information

Prescriber Name: Prescriber NPI:

Facility Name: State License #:

Facility Address: City: State: ZIP:

Primary Office Contact: Fax Number:

Phone Number: Office Contact Email:

Product and Prescription Information

Collagenase **SANTYL®** Ointment 250 units/gram - Apply daily as directed. Enter Wound Length and Wound Width for up to six (6) wounds, attach clinical notes for any additional wounds:

Wound 1: **Length:**_____ cm **Width:**_____ cm

Wound 2: **Length:**_____ cm **Width:**_____ cm

Wound 3: **Length:**_____ cm **Width:**_____ cm

Wound 4: **Length:** _____ cm **Width:** _____ cm

Wound 5: **Length:** _____ cm **Width:** _____ cm

Wound 6: **Length:** _____ cm **Width:** _____ cm

Duration of Therapy (Days):_____

Rx Refills:_____ **SANTYL Rx** written for: ☐ Burn ☐ Chronic Wound **For BURN use:** TBSA _____ **Number of Applications:** _____

Prescriber Certification Signature:

I certify that the information provided in this Patient Assistance Program Application is complete and accurate to the best of my knowledge, that the Smith+Nephew product I have prescribed to the applicant within this application is based on my professional judgment of medical necessity for a Food and Drug Administration (FDA) approved indication, and that I will supervise the patient's medical treatment. I will notify Smith+Nephew PAP immediately if the Smith+Nephew product is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorizations for the release of my patient's personal identification and insurance information to Smith+Nephew and their agents and representatives. I understand that any information provided is for the sole use of Smith+Nephew and their agents and representatives to verify my patient's insurance coverage status, to assess the patient's eligibility for participation in the Smith+Nephew Patient Assistance Program (collectively, "the Program"), and to otherwise administer the product and related services. I understand that application to the Program does not guarantee that assistance will be obtained. I understand that Smith+Nephew may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Program, and I agree to immediately notify a Smith+Nephew PAP representative if I become aware of changes in the patient's financial and/or insurance status. I agree that Smith+Nephew PAP may contact me for additional information relating to this application either by fax, e-mail and/or telephone. I understand that I am under no obligation to prescribe any Smith+Nephew product and that I have not received, nor will I receive any benefit from Smith+Nephew or their agents or representatives for prescribing a Smith+Nephew product. I agree that I will not submit claims or make any attempt to receive reimbursement for product provided by the Program. By signing this Patient Assistance Program Application, I authorize the release of medical and/or other patient information to agents and service providers of Smith+Nephew (including but not limited to Sonexus Health LLC and the dispensing non-commercial pharmacies) to use and disclose as necessary for verification of patient eligibility, and to furnish any information on this form to the insurer of the applicant for the purpose of verifying benefit eligibility.

Prescriber Signature: _____ Date: _____

(original signature required)

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Patient Authorization and Agreement Signature

By signing this Authorization, I authorize each of my physicians, pharmacists, including any non-commercial pharmacy that receives my prescription for SANTYL◊ (together "my Prescribed Product), and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Smith+Nephew, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Smith+Nephew") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting the Smith+Nephew Patient Assistance Program (PAP) (collectively, the "Program") for Healthcare Providers and patients for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

I. Enroll me in, and contact me about the Program, including online support, financial assistance services, and co-pay assistance services,
II. Communicate with my Healthcare Providers and Insurers about benefits, coverage, and medical care, including compliance with Product treatments,
III. Facilitate dispensing of my prescription by a non-commercial pharmacy,
IV. Provide me with educational materials, information and services related to my treatment experience with my prescribed medication and my condition,
V. Verify, investigate, and coordinate with my Insurers regarding my prescribed medication,
VI. Conduct surveys, data analytics, market research and other internal business activities related to the Program and Smith+Nephew products and programs, and
I. Contact me as otherwise required or permitted by law.

Once my Protected Health Information has been disclosed to Smith+Nephew, I understand that federal privacy laws no longer protect the information. However, Smith+Nephew agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Smith+Nephew Patient Assistance Program and the services provided by Smith+Nephew under the Program. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.
I understand that my signed Authorization is valid for 5 yrs from date of signature, and that I may revoke this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the Authorization. I understand that to revoke this Authorization I may mail a request to 2730 S. Edmonds Lane, Suite 300 Lewisville, TX 75067, fax to 833-965-1621, or by calling 833-965-1620. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

I understand that if I qualify and I am enrolled in the Program sponsored by Smith+Nephew, I will receive my Prescribed Product from Smith+Nephew only pursuant to a legally valid prescription from my health care provider. I understand that if I qualify and I am enrolled in the Program, Smith+Nephew will provide me my Prescribed Product free of charge for the duration of the enrollment period so long as I have a legally valid prescription for my Prescribed Product. I understand that I am not required to continue treatment with my Prescribed Product if I gain insurance coverage, or to receive treatment from any given provider. I understand and agree that I must notify Smith+Nephew PAP at 833-965-1620 immediately if my insurance status changes during the Program enrollment period. I understand and agree that neither I nor my Insurers, if applicable, will be charged for the supply of my Prescribed Product that I received from the Program, and that under NO circumstances may I claim reimbursement from my Insurers or any related third party for the Prescribed Product provided to me free of charge from the Program. I understand that Smith+Nephew reserves the right at any time without notice to modify or discontinue the Program and its criteria.

I understand that I am providing 'written instructions' to Smith+Nephew and its vendor Sonexus Health, LLC under the Fair Credit Reporting Actauthorizing Sonexus Health, LLC on behalf of Smith+Nephew to obtain information from my credit profile or other information from Experian Health. I authorize Smith+Nephew and its partnered provider Sonexus Health to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial screening process.

Sign here (Required)

My signature certifies that I have read and understand the above statements and agree to the outlined terms.

Patient Name: _____ Patient Signature: _____ Date: _____

(Used only when the patient is incapacitated and therefore unable to sign the Authorization)

Personal Representative Name: _____ Personal Representative Signature: _____ Date: _____

Patient Authorized Representative - (Use only if patient is unable to sign)

I permit Smith+Nephew PAP Support Services representatives to speak with the following person about this application form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, or any other treatment-related issues. I may cancel this Patient Authorized Representative Authorization at any time by calling: 833-965-1620.

Name of Authorized Representative: _____ Relationship to Patient: _____

Telephone Number: _____ Email: _____

By signing below, I, the patient, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

Patient Signature: _____ Date: _____

(Or Personal Representative if the patient is otherwise unable to sign this Authorization)

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Autorización del paciente y firma del acuerdo

Al firmar esta Autorización, autorizo a cada uno de mis médicos, farmacéuticos, incluida cualquier farmacia no comercial que reciba mi receta de SANTYL◊ (en conjunto, "mi Producto recetado") y a otros proveedores de atención médica (en conjunto, "Proveedores de atención médica"), así como a cada una de mis aseguradoras (en conjunto, las "Aseguradoras") a divulgar mi Información de salud protegida, que incluye, entre otros, registros médicos, información relacionada con mi afección y tratamiento médicos, mi cobertura de seguro de salud, mi nombre, dirección, número de teléfono, número de Seguro Social, número de plan de seguro o de grupo (en conjunto, "Información de salud protegida") a Smith+Nephew, sus empresas afiliadas, proveedores, agentes, socios colaboradores y representantes (en conjunto, Smith+Nephew), incluidos los proveedores de fuentes alternativas de financiamiento para los costos de medicamentos recetados y otros proveedores de servicios que apoyan el Programa de Asistencia al Paciente (Patient Assistance Program, PAP) de Smith+Nephew (en conjunto, el "Programa") para Proveedores de atención médica y pacientes para los fines que se describen a continuación.

Específicamente, autorizo la divulgación de mi Información de salud protegida con los siguientes propósitos:

I. Inscribirme y comunicarse conmigo en relación con el Programa, incluido el apoyo en línea, los servicios de asistencia financiera y los servicios de asistencia para copagos.
II. Comunicarse con mis Proveedores de atención médica y Aseguradoras sobre los beneficios, la cobertura y la atención médica, incluido el cumplimiento de los tratamientos con el Producto.
III. Facilitar la dispensa de mis medicamentos recetados por una farmacia no comercial.
IV. Proporcionarme materiales educativos, información y servicios relacionados con mi experiencia de tratamiento con mi medicamento recetado y mi afección.
V. Verificar, investigar y coordinar servicios con mis Aseguradoras con respecto a mi medicamento recetado.
VI. Realizar encuestas, análisis de datos, estudios de mercado y otras actividades comerciales internas relacionadas con el Programa y los productos y programas de Smith+Nephew.
VII. Ponerse en contacto conmigo según lo requiera o permita la ley.

Una vez que mi Información de salud protegida se haya divulgado a Smith+Nephew, entiendo que las leyes federales de privacidad ya no protegen la información. Sin embargo, Smith+Nephew acepta proteger mi Información de salud protegida usándola y divulgándola solo para los fines descritos en esta Autorización o según lo permita la ley. Entiendo que puedo negarme a firmar esta Autorización. Mi decisión de firmar no cambiará la forma en que mis Proveedores de atención médica o Aseguradoras me tratan, pero no tendré acceso al Programa de Asistencia al Paciente de Smith+Nephew ni a los servicios proporcionados por Smith+Nephew en el marco del Programa. Si me niego a firmar la Autorización, o revoco mi Autorización más adelante, entiendo que esto significa que no podré participar ni recibir asistencia del Programa.

Entiendo que mi Autorización firmada es válida por 5 años a partir de la fecha de la firma, y que puedo revocar esta Autorización en cualquier momento en el futuro, excepto en la medida en que se hayan tomado medidas con base en la Autorización. Entiendo que, para revocar esta Autorización, puedo enviar una solicitud por correo postal a 2730 S. Edmonds Lane, Suite 300 Lewisville, TX 75067; por fax al 833-965-1621 o por teléfono al 833-965-1620. Entiendo que revocar esta Autorización pondrá fin a los usos y divulgaciones adicionales de mi Información de salud protegida por parte de las partes identificadas anteriormente, excepto en la medida en que esos usos y divulgaciones se hayan realizado de acuerdo con esta Autorización según lo permitido por la ley vigente. Tengo derecho a recibir una copia de esta Autorización.

Entiendo que estoy proporcionando "instrucciones escritas" a Smith+Nephew y a su proveedor Sonexus Health, LLC, conforme a la Ley de Informe Imparcial de Crédito (Fair Credit Reporting Act), para autorizar a Sonexus Health, LLC en nombre de Smith+Nephew a obtener información de mi perfil crediticio u otra información de Experian Health. Autorizo a Smith+Nephew y a su proveedor asociado, Sonexus Health, a obtener dicha información únicamente con el fin de determinar las calificaciones financieras para el Programa. Entiendo que debo aceptar los términos de este aviso con mi firma a continuación para continuar con el proceso de evaluación financiera del Programa.

Firma aquzí

Con mi firma, certifico que he leído y comprendido las declaraciones anteriores y que estoy de acuerdo con los términos descritos.

Nombre del paciente: (letra de imprenta) _____ Firma del paciente: _____ Fecha: _____

(Se usa solo cuando el paciente está incapacitado y, por lo tanto, no puede firmar la Autorización)

Nombre del representante personal: _____ Firma del representante personal: _____ Fecha: _____

Representante Autorizado por el Paciente - (Úselo solo si el paciente no puede firmar.)

Permito que los representantes de los Servicios de Asistencia del PAP de Smith+Nephew hablen con la siguiente persona sobre este formulario de solicitud. Esto incluye analizar el estado de mi solicitud, preguntas sobre seguros y finanzas, cualquier documentación faltante y otros asuntos relacionados con mi inscripción, o cualquier otro asunto relacionado con el tratamiento. Puedo cancelar esta Autorización para el representante autorizado del paciente en cualquier momento llamando al: 833-965-1620

Nombre del representante autorizado: _____ **Relación con el paciente:** _____

Número de teléfono: _____ **Correo electrónico:** _____

Al firmar a continuación, yo, el paciente, permito que este representante hable en mi nombre sobre cualquier asunto relacionado con mi inscripción en el Programa.

Firma del paciente: _____ Fecha: _____

(o representante personal si el paciente no puede firmar esta Autorización)