Vivimusta CONNECT℠

Directions: For assistance, please complete this form and fax it to 1.855.854.3931. You can also call 1.844.472.2628, Monday-Friday 8 AM–6 PM ET, to speak with a **Vivimusta CONNECT℠** Case Manager.

Vivimusta® (bendamustine HCl injection)

PATIENT ASSISTANCE PROGRAM – ENROLLMENT FORM (Patient MUST Be Uninsured)

REQUIRED FIELDS ARE MARKED IN **BOLD**. PLEASE NOTE THAT MISSING INFORMATION WILL DELAY OUR ABILITY TO ASSIST YOU IN ACCESSING THERAPY

1 PATIENT DEMOGRAPHIC INFORMATION

First Name:		**Last Name:**	
DOB:	Sex:	**Street Address:**	
City:		**State:**	**ZIP Code:**
Phone:		Consent to Contact? ◯ Yes ◯ No	
Contact for Legal Guardian (Complete if patient is <18 years old)		First Name:	Last Name:
Relationship to Patient:		Phone:	

2 PATIENT FINANCIAL INFORMATION

Annual Household Adjusted Gross Income:	Number of People Living in Household:

3 PHYSICIAN INFORMATION

First Name:		**Last Name:**	Title:
Facility Name:		**Street Address:**	
City:	**State:**	**ZIP Code:**	**Phone:**
Fax:	Contact Name:	Direct # or Extension:	
Tax ID #:	**NPI #:**	Email:	

4 TREATMENT INFORMATION

Patient Diagnosis: (List all that apply)	**ICD-10-CM Diagnosis Code(s):** (List all that apply)

5 PRESCRIPTION (Complete this section only if the patient is applying to the patient assistance program)

Vivimusta® (bendamustine HCl) injection 100 mg/4 mL (25 mg/mL) multi-dose vial

Directions: Administer ____mg intravenously over 20 minutes. On Days 1 and 2 of a (select one) 21-day cycle 28-day cycle

Date(s) of Next Infusion(s):

Dispense Quantity (# of individual doses): **Refills:** **PRN for 1 year**

6 PRESCRIBER CERTIFICATION AND SIGNATURE

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) the information provided is complete and accurate to the best of my knowledge; (3) I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Azurity Pharmaceuticals and its affiliates, vendors, and agents for purposes relating to the Vivimusta CONNECT℠ Program and forwarding the above prescription by fax or other means of delivery to a licensed pharmacy to dispense Vivimusta where appropriate; and (4) I have prescribed the medication to this patient based on my professional judgment of medical necessity, for an on-label diagnosis. (5) I will immediately notify Azurity Pharmaceuticals, Inc. if my patient is enrolled in the program and I become aware that their insurance or treatment status has changed. (6 I will not submit an insurance claim or other claim for payment to anyone else, including a third-party payer (private or government) or the patient, and I will forego appeals for any denial of insurance coverage for medication provided by Azurity Pharmaceuticals, Inc. for the patient.

Prescriber Signature:	**Date:**

7 PATIENT AUTHORIZATION AND CONSENT

Patient Authorization: By signing below, I authorize my healthcare providers and their staff, including any specialty pharmacies that dispense my medication, and my health insurer(s)/health plan(s) (collectively, my "healthcare team"), to disclose to Azurity Pharmaceuticals, Inc., its affiliates, vendors, and agents (collectively, "Azurity Pharmaceuticals, Inc."), information related to me and my medical condition and treatment, including but not limited to prescriptions, and my health insurance coverage and claims (collectively, "My Information"), for the purposes of enrolling me in Vivimusta CONNECT℠ and providing me with certain services and information. Specifically, I authorize such disclosures to Azurity Pharmaceuticals, Inc. to use and share my Information with my healthcare team to: (1) establish my eligibility for insurance to cover Vivimusta®; (2) facilitate my obtaining Vivimusta®; (3) contact me regarding my enrollment and participation in the Program and my use or potential use of Vivimusta®; (4) provide me with information about Vivimusta® and other products, including promotional and educational communications. I also have reviewed and agree with the Terms and Conditions for the Vivimusta CONNECT℠ Terms and Fair Credit Reporting Act Authorization for the Vivimusta CONNECT℠ Patient Assistance Program on page 2 of this form. I understand that the services provided by these programs may be revised, changed, or terminated at any time. I understand that my healthcare providers, health plans, and/or specialty pharmacy(ies) may receive remuneration from Azurity Pharmaceuticals, Inc., in exchange for providing me with support services. I certify that I am at least 18 years old

Signature of Patient or Legal Representative:	**Date:**
Legal Representative Relationship to Patient: (Complete if legal representative signs above)	Print Name of Legal Representative:

Vivimusta CONNECT℠ Patient Assistance Program and Fair Credit Reporting Act (FCRA) Authorization

If you, the patient, provide financial information and sign the Patient Authorization and Patient Consent on page 1 of the Vivimusta CONNECT℠ Enrollment Form, you are seeking eligibility consideration from the Vivimusta CONNECT℠ Patient Assistance Program, and you understand and agree with these terms and conditions:

- I understand that once my Information has been disclosed as authorized, federal privacy law may no longer restrict its further disclosure to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described or as required by law.
- I understand that my refusal to sign this Authorization will not affect my right to treatment or payment for healthcare and that, if I do sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to the Vivimusta CONNECT℠ Patient Assistance Program, 601 South Lake Destiny Rd. Suite 300 Maitland, FL 32751; however, such withdrawal will not invalidate uses and disclosures of my Information made prior to the Program's receipt of the withdrawal notice. I am entitled to a copy of this signed Authorization, which expires five (5) years from the date I sign it or at such earlier time as may be required by state law.
- I understand that I am authorizing the Vivimusta CONNECT℠ Program, under the FCRA, to obtain information from my credit profile or other information from consumer reporting agencies for the purpose of determining financial qualification for the Vivimusta CONNECT℠ Patient Assistance Program. I understand that I must affirmatively agree to these terms in order to proceed with this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, including Medicaid, Medicare, any public or private assistance programs, or other form of insurance. I understand that, upon request, Vivimusta CONNECT℠ will tell me whether it requested an individual consumer report and the name and address of the agency that furnished it. If my income or health coverage changes, I will call Vivimusta CONNECT℠ at 1.844.472.2628.
- I also understand that, to qualify for the Vivimusta CONNECT℠ Patient Assistance Program, I must meet certain income and other eligibility requirements. I confirm my agreement with the conditions and certify that the information I have set forth in this application, including the number of people living in my household and my household income, are true and accurate to the best of my knowledge. I understand that Vivimusta CONNECT℠ may ask for proof of income at any time for the purpose of an audit or verification. If requested, I agree to provide proof of income within 45 days of the request. Continuation in the Program is conditioned upon timely verification of income. I certify and attest that I will promptly contact Vivimusta CONNECT℠ if my financial status or insurance coverage changes.
- I understand that any drugs provided under the Vivimusta CONNECT℠ Patient Assistance Program shall not be sold, traded, bartered, or transferred.
- I understand I must be a permanent resident of the U.S. or U.S. territory (including Guam, Puerto Rico, and the Virgin Islands).
- I understand that any program assistance provided by Vivimusta CONNECT℠ will terminate if the Program becomes aware of any fraud or if this medication is no longer prescribed for me. I certify that I cannot afford this medication.
- I understand that completing this application does not ensure that I will qualify for this Program.
- I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payer.
- Azurity Pharmaceuticals, Inc. reserves the right to modify or cancel the Vivimusta CONNECT℠ Patient Assistance Program, or terminate my enrollment, at any time, without prior notice.
- The support provided through this program is not contingent on any future purchase.

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