Arbor Pharmaceuticals Patient Assistance Program ("PAP")
Administered by: Truax Patient Services
1112 Railroad Street SE, Suite #4,
Bemidji, MN 56601
Phone: (877) 438-9759 Fax: (877) 619-6574

Dear Applicant,

Thank you for your interest in the Arbor Pharmaceuticals, LLC Patient Assistance Program ("Program"). Enclosed you will find the requested application. To participate in our Program, it is important that you complete all requested information and sign where indicated. Incomplete applications will not be processed until missing information is received.

PATIENT REQUIREMENTS:

- Must be a U.S. citizen or resident, with a valid Social Security Number.
- Patient must have no insurance coverage either private and/or public
    - Medicare Part D Applicants: If Part D does not allow or pay for any part of your medication, you will be viewed as having no insurance. Being in the donut hole does **not** qualify.
- Provide a list of other medications you are currently on.
- Must be under the care of a licensed healthcare provider who is authorized to prescribe medicine in the U.S.
- Complete and sign the Patient Information Section
- Proof of ANNUAL household income documentation is required with each application.
    - Acceptable forms of documentation include:
        - Copy of most recently filed Income Tax Return (IRS Form 1040) or W-2 -or-
        - Copy of transcript received through submission of IRS 4506-T -or-
        - Copy of most recent Social Security/Disability monthly check, award letter, benefit statement of 1099 -or-
        - Copy of Unemployment Determination letter
        - Certified letter stating you have no income in your total household

HEALTHCARE PROVIDER REQUIREMENTS:

- Complete and sign the Healthcare Provider Information section.
- ***Mail, fax or scan the completed application along with a 90-day supply prescription with refills for chronic medication or as prescribed prescription for acute care medication to Truax Patient Services.***
- Provide NPI and DEA Number.

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:

Household Income Requirement: Patient must not have a household income that exceeds 300% of the current US Federal Poverty Guideline (FPL) for BiDil®, and 200% of current US FPL for all other products:

Persons in Household	Annual Income – 200% FPL	Annual Income – 300% FPL (BiDil)
1	$25,760	$38,640
2	$34,840	$52,260
3	$43,920	$65,880
4	$53,000	$79,500
5	$62,080	$93,120

For each additional person(s) add $9,080 for 200% or add $13,620 for 300%

Alaska and Hawaii residence: Please ask Truax Patient Services or find on-line your states US FPL amounts.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- MAIL: Truax Patient Services / 1112 Railroad Street SE, Suite #4 / Bemidji, MN 56601
- FAX: (877) 619-6574
- Email: bwtruax@truaxpatientservices.com

revised 2/3/2021

Medication will be mailed to the patient through Truax Patient Services Pharmacy, unless viewed as a health risk to be mailed to patients address. You will be notified upon completion of our review and evaluation. Please note, Program rules are subject to change without notice. If you have questions or need further assistance, please call (218-444-8217), between 9:00AM and 5:00PM Central Standard Time, Monday through Friday.

Sincerely,
Arbor Pharmaceuticals, LLC
Patient Assistance Program

Arbor Pharmaceuticals Patient Assistance Program

Truax Patient Services / Individual Patient Assistance Program Application

1112 Railroad Street SE, Suite #4 / Bemidji, MN 56601 / Phone: (877) 438-9759 / Fax: (877) 619-6574

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN					
FIRST NAME:	**MI:**	**LAST NAME:**			**DOB: / /**
Mailing Address:		City:		State:	Zip:
Social Security #:		Phone #: ( )			
Contact person if different from above:			Phone #: ( )		
Drug Allergies:					
Medications currently on:					

PATIENT ELIGIBLITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)
TOTAL ANNUAL HOUSEHOLD INCOME: $_____ (include all annual income, wages, social security, pension, disability, interest earned on savings, etc.)
Household Size (number of persons living in the home) :
Are you currently enrolled in a Medicare Part D Prescription Drug Plan? YES____ NO____
Do you have any public or private prescription drug coverage or are you in any benefit program that helps pay for your prescription drugs? **YES____ NO____**

I certify that all of the above information is complete and accurate. I attest that I have insufficient financial resources to pay for the prescribed medication. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. My signature certifies that the medication received from Truax Patient Services will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that support services will terminate if the PAP becomes aware of any fraud or if this medicine is no longer prescribed for me. I understand that completing this PAP application does not ensure that I will qualify for patient assistance. I understand and acknowledge that this assistance is temporary and that this Program may be changed or discontinued at any time without notice.

Patient's Signature:_____ **Date:** _____

HEALTHCARE PROVIDER INFORMATION: TO BE COMPLETED BY TH PRESCRIBING PRACTITIONER		
First Name:	Last Name:	MD DO NP PA
Facility Name:	NPI #:	DEA#
Street Address:		
City:	State:	ZIP:
Phone Number:	Fax Number:	

I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that Arbor Pharmaceuticals PAP and /or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage, including Medicaid, Medicare or other public or private programs. I understand that PAP reserves the right to modify or terminate this Program at any time. I understand that PAP reserves the right to recall or discontinue medication at any time without notice.

Healthcare Provider Signature:_____ Date:_____

Truax Patient Services
Individual Patient Assistance Program Application Disclosure Section
1112 Railroad Street SE, Suite #4 / Bemidji MN 56601 / Phone (877) 438-9759 / Fax (877) 619-6574

AUTHORIZATION TO USE OR DISCLOSE HEALTHINFORMATION:

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

Persons/organizations authorized to use or disclose the information: My insurer, pharmacist, physician, or other health care provider.

Purpose of requested use or disclosure: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.

This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.

EXPIRATION:

This Authorization expires one (1) year after I cease to participate in the Program.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling (877) 438-9759 and mailing a written revocation, signed by me or on my behalf, to Truax Patient Services 1112 Railroad St SE STE#4, Bemidji, MN 56601. My revocation will be effective upon receipt but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization.

Patient Signature:_____ Date_____