SHORLA SOLUTIONS

PATIENT ASSISTANCE PROGRAM

Send completed, signed and dated enrollment forms (applications) to:

EVERSANA, Shorla Oncology Patient Assistance Program
17877 Chesterfield Airport Rd
Chesterfield, MO 63005
or Fax to 1 (866) 779-6296
Program Inquires: 1 (844) 9SHORLA (974-6752) Option #4

PROGRAM INFORMATION

As part of our commitment to patients and health care providers, the Shorla Oncology Patient Assistance Program (PAP) provides select Shorla Oncology branded products free of charge to patients who do not have prescription drug coverage or cannot afford their medication.

To be eligible for PAP, both the prescribing health care professional AND the patient must complete, sign and date this program application form and certify that:

1. The patient is a legal resident in the United States.
2. The patient is under the care of a licensed US physician and has a valid prescription for an FDA approved indication.
3. The patient does not have health insurance or coverage for prescription medications.
4. The patient cannot afford to pay for the medication and the patient meets the Program's financial eligibility criteria.

PATIENT MUST COMPLETE SECTIONS 1, 2 AND 3 ON THIS SIDE OF THE FORM

SECTION 1: THE PATIENT INFORMATION

Patient's First Name: _____ Patient's Last Name: _____

Address Line 1: _____

Address Line 2 (Apartment/Unit Number): _____

City: _____ State: _____ Zip: _____

Date of Birth: MM/DD/YYYY _____ U.S. Resident: ☐ Yes ☐ No

Provide an email address and a mobile number so we may contact you with program notifications and updates.

Email: _____

Mobile Phone: _____ Home Phone: _____

Provide current gross annual household income (your income before taxes), including Social Security and pension benefits.

Total gross annual household income: $_____ Household members relying on this income (including patient) : _____

Do you have insurance or other prescription drug coverage: ☐ Yes ☐ No

SECTION 2: INSURANCE AND INCOME VERIFICATION

I understand the Shorla Oncology PAP will verify information about my current gross annual household income and they will run a benefit verification to confirm I do not have insurance or prescription drug coverage.

By signing below, I am providing authorization to Shorla Oncology and other individuals involved in administering the Shorla Oncology PAP to run a benefit check and an income Experian check.

Patient Signature: _____ **Date:** MM/DD/YYYY

SECTION 3: APPLICANT DECLARATIONS AND AUTHORIZATION

I certify that all information provided in this application (including household income) is complete and accurate. I understand that completing this application does not ensure that I will qualify for this program. I certify that I cannot afford this medication. I certify that I will not seek reimbursement for this prescription from any insurer, health plan or government program. If I have Medicare insurance, I am certifying that I do not have prescription drug coverage. I understand that the Shorla Oncology PAP reserves the right to modify, discontinue, or terminate assistance at any time without notice. I understand that Shorla Oncology PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application. I authorize Shorla Oncology and its affiliates to forward this prescription to a dispensing pharmacy on my behalf. Shorla Oncology is not acting as a dispensing pharmacy. Shorla Oncology is not responsible for verifying any information contained in Section 2 of the form including without limitation, allergies, medical conditions, or other medications being taken by me. I understand that only the dispensing pharmacy will be responsible for the information contained in Section 2 of this application form. I understand that assistance received through the Shorla Oncology PAP is not insurance. Through my submission of the Shorla Oncology PAP enrollment form, I consent to the collection, use, and disclosure of my personal health data. My consent is required to process sensitive personal data under certain privacy laws.

Patient Signature: _____ **Date:** MM/DD/YYYY

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PHYSICIAN/PRESCRIBER MUST COMPLETE THIS SIDE OF THE FORM AND SIGN
SECTION 4: PHYSICIAN/PRESCRIBER INFORMATION

Prescriber's First Name: _____ Prescriber's Last Name: _____

Prescriber's Professional Designation: _____ Name of Office/Facility/Site: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Prescriber's NPI Number: _____

Office Phone: _____ Secure Fax: _____

Office Contact Name: _____ Email: _____

SECTION 5: COMPLETE THE PRESCRIPTION BELOW (PLEASE PRINT)

Prescription

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: MM/DD/YYYY

Medication Name	Strength	Directions	Quantity	Refills
Jylamvo™ (methotrexate) Oral Solution	2mg/mL	Take _____mL(s) by mouth _____ time(s) per day	_____ (1 bottle is 60 mL)	☐ 1 Year ☐ Other:_____
Imkeldi (imatinib) Oral Solution	80mg/mL	Take _____mL(s) by mouth _____ time(s) per day	_____ (1 bottle is 140 mL)	☐ 1 Year ☐ Other:_____

Allergies: _____ Medical Conditions: _____

Patient's Current Medication(s): _____

Physician/Prescriber Attestation

I certify that the above therapy is medically appropriate/necessary and this information is accurate to the best of my knowledge. I certify that I am the provider who has prescribed the drug listed above for the patient named on this form. I authorize Shorla Oncology, and its affiliates companies or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. I understand that Shorla Oncology reserves the right to modify, discontinue, or terminate the program at any time and without notice. I understand that Shorla Oncology PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application as it relates to the Shorla Oncology PAP for the purpose of determining eligibility of the patient.

Physician/Prescriber Signature: ORIGINAL SIGNATURE **Date:** MM/DD/YYYY

An incomplete form will result in a processing delay | Program Inquires: 1 (844) 9SHORLA (974-6752) Option #4