Boehringer Ingelheim Cares Foundation

BI Cares Patient Assistance Program

The Boehringer Ingelheim Cares Foundation (BI Cares) Patient Assistance Program is free of charge to eligible US patients who apply to and are enrolled in the program.

Please Note: The Boehringer Ingelheim Cares Foundation is not affiliated with any third-party individual or organization that may charge patients a fee(s) to assist them in applying to our program or ordering refills through our program. These individuals or organizations are acting independently of the Boehringer Ingelheim Cares Foundation and do not have our Foundation's consent.

Who is eligible?

All applications are reviewed in accordance with BI Cares program eligibility criteria. To be eligible, you must:

- ❑ Be a resident with a physical address within the United States or US Territory
- ❑ Have one of the insurance coverage circumstances outlined below:
  - No health coverage
  - Not enough coverage to obtain the medication (eligible drugs are listed below)
- ❑ Not have access to alternate sources of coverage or funding for your medication
- ❑ Meet household income guidelines established by BI Cares

What information is needed to submit an application?

The following items should be submitted to the BI Cares Patient Assistance Program for the application to be considered complete:

- ❑ Complete Sections 1-4 including signatures
- ❑ Have a Healthcare Provider complete Sections 5 & 6 including an original signature

What medications are eligible?

The following medications are eligible for the BI Cares Patient Assistance Program:

- Aptivus®
- Atrovent® HFA
- Combivent® Respimat®
- Glyxambi®
- Jardiance®
- Jentadueto® & Jentadueto® XR
- Pradaxa®
- Spiriva® Handihaler®
- Spiriva® Respimat®
- Stiolto® Respimat®
- Striverdi® Respimat®
- Synjardy® & Synjardy® XR
- Tradjenta®
- Trijardy® XR
- Viramune® XR

Contact Us:
BI Cares Patient Assistance Program
P.O. Box 5520, Louisville, KY 40255
Phone: 1-800-556-8317 Fax: 1-866-851-2827

Hours of Operation:
Monday – Friday
8:30 AM – 6:00 PM ET

Section 1: Patient Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

***Note**: Delivery will be to patient's address unless otherwise indicated by the patient. Aptivus® & Viramune® XR will be shipped to the Healthcare Provider.*

Preferred Daytime Phone Number *: ( ) _____

* I authorize Boehringer Ingelheim Cares Foundation, Inc. ("BI Cares") and its affiliates, agents, representatives and service providers to use auto-dialers, prerecorded messages, artificial voice messages and messages to contact me at the number I provided above and that these calls may be informational and marketing related and mention the name of BI Cares and of services or products offered by BI Cares, including Boehringer Ingelheim drug products, details about my insurance coverage and my doctor's name. I understand I am not required to consent to being contacted by auto-dialers, prerecorded messages, artificial voice messages and text messages as a condition of enrollment in BI Cares and if I do not consent, I will not provide my phone number. Standard message and data rates may apply.

Please Send me Text Notifications on Program & Shipment Statuses: ☐ Yes ☐ No

***If Yes** and if you would like to receive the text notifications on a different phone number than above, please provide the preferred phone number for text notifications:* ( ) _____ – _____

Date of Birth (MM/DD/YYYY): ____ / ____ / _____

Gender (Please Check): ☐ Male ☐ Female Last 4 Digits of SSN: _____

***Note:** This is Required for Income Verification*

Preferred Language (Please Check): ☐ English ☐ Spanish ☐ Other: _____

Section 2: Patient Financial Information

How many people live in your household (including yourself)? _____

What is the total household income for a year? $ _____

Total patient household assets (Include 401(k), second home, IRA, etc. Do not include primary home or car)) $ _____

I understand that to qualify for free product my adjusted gross income must meet the Program income guidelines and that my income will be validated through Experian's household income assessment tool ("Experian") based on the information I provide. If my income cannot be verified through Experian, BI Cares will request documentation from me such as my IRS 1040 form or other proof of income to verify my financial information. I agree to provide such information in a timely manner. BI Cares may request information from me, my health care provider or my insurance company to verify my insurance information. I understand that any free product provided to me through BI Cares is contingent upon my meeting eligibility criteria; and that BI Cares reserves the right to make an independent determination of my financial and medical need.

X _____ _____

Patient (or Authorized Representative) Signature Date

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First Name: _____ Last Name: _____

Section 3: Insurance Information

	Check One	
Have you received disability payments from Social Security for more than 24 months?	☐ Yes	☐ No
Have you received a denial letter from Medicare Low Income Subsidy?.... *If yes, please attach a recent copy of this letter along with your application.*	☐ Yes	☐ No
Do you have Medicare Part D or Medicare Advantage?	☐ Yes	☐ No
Do you have Medicaid?	☐ Yes	☐ No
Do you have prescription drug coverage from a commercial or private health insurer? (Not including Part D prescription benefits).....	☐ Yes	☐ No
Do you receive Veterans Affairs Benefits?	☐ Yes	☐ No

Section 4: Patient Attestation & HIPAA Authorization

Patient Attestation

The information you, the Patient, provides as part of this BI Cares Patient Assistance Program application ("Application") will be used by Boehringer Ingelheim Cares Foundation, Inc. ("BI Cares") and its affiliates, agents, representatives and service providers, including Experian, to:

(1) process this Application and verify the information contained in this Application,
(2) administer, analyze, and improve the BI Cares Patient Assistance Program ("Program"),
(3) improve and tailor our products and services to better serve you,
(4) communicate with you about your experience with the Program or Boehringer Ingelheim product,
(5) contact your prescribing physician in follow up to a medical question about your treatment with a Boehringer Ingelheim product, and/or
(6) send you materials and other helpful information and updates relating to BI Cares programs ("Services").

By signing below, you, the Patient, attest and certify that:

- The information provided in this Application and any additional information provided as part of the Application process is current, complete, and accurate to the best of your knowledge.
- You cannot afford the medication requested and (1) have no coverage or (2) have no coverage for this medication or (3) have coverage for the medication but have an out-of-pocket expense you cannot afford.
- You will not seek reimbursement from any insurer or government program for any medication dispensed from the Program.
- You will notify the Program immediately if the medication requested is no longer medically necessary for your treatment or if your insurance or financial status has changed.

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First Name: _____ Last Name: _____

In addition, by signing below, you, the Patient, understand and agree that:

- Any medication supplied as a result of this Application is for your use only, and shall not be sold, traded, bartered, transferred, returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to you.
- The information provided in this Application is subject to random audits and verification. During such audits and verification processes, you may be asked for additional supporting documentation.
- BI Cares may change this Program at any time and reserves the right to terminate your enrollment at any time due to lack of eligibility or related factors.
- Additional information may be requested to process this application including verification of your income through sources such as Experian.
- The medication made available to you under this Program may be denied if you do not fully cooperate with efforts made to verify the information provided in this application, or if you do not take steps to secure other forms of payment for your medication after being notified of other programs for which you may be eligible.
- BI Cares is not obligated to verify any of the information contained in this Application or to confirm other medications that you are taking.

HIPAA Authorization

By signing below, you, the Patient, hereby authorize:

- Your physicians, health care providers, pharmacy providers, and health plans to disclose to BI Cares and its affiliates, agents, representatives and service providers, including Experian, ("Recipients") your individually identifiable health information, which may include information related to your medical condition, treatment, care management, health insurance, medication history, and prescriptions ("Health Information").
- The Recipients to access, obtain, use, disclose, receive, and maintain your Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of, or determining eligibility under, other patient assistance resources, contacting your prescribing physician in follow up to a medical question about your treatment with a Boehringer Ingelheim product, and conducting the additional Services described above.

In addition, by signing below, you, the Patient, understand and agree that:

- This authorization is voluntary, but if you do not sign it, you will not be able to participate in the Program. Your physicians and healthcare providers may not condition the provision of your treatment on your signing this authorization.
- Information released under this authorization may no longer be protected by state and federal law.
- You may withdraw your authorization at any time by mailing a written withdrawal to BI Cares at the address below, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- If you do not withdraw your authorization, this authorization will be in effect for one year from the date of enrollment if approved for the program.
- Your pharmacy may receive compensation in exchange for reports containing your information.

X _____ _____

Patient (or Authorized Representative) Signature Date

Mail or Fax the Complete Application to:

BI Cares Patient Assistance Program
P.O. Box 5520, Louisville, KY 40255
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Section 5: Prescriber Information

Prescriber Name: _____ NPI: _____

Specialty: _____ SLN #: _____ SLN Exp. Date: _____

Site/ Facility Name: _____ Office Contact Name: _____

Address _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Section 6: Prescription & Medication Information*

First Name: _____ Last Name: _____ Date of Birth: ___/___/___

Product Name/ Strength: _____ Days Supply: 90 days

Directions: _____ Refills (check one): ☐1 ☐2 ☐3

Medication Allergies? ☐Yes ☐No If Yes, please list all drug allergies: _____

Current Medications (please list): _____

* *A separate prescription form may be attached to this application and a separate form should be attached if required by federal and state law.*

The information you, the Prescriber, provides as part of this BI Cares Patient Assistance Program application ("Application") will be used by Boehringer Ingelheim Cares Foundation, Inc. ("BI Cares") and its affiliates, agents, representatives and service providers to (1) process this Application and verify the information contained in this Application, (2) administer, analyze, and improve the BI Cares Patient Assistance Program ("Program"), (3) improve and tailor our products and services to better serve you, (4) communicate with you about your experience with the Program, and/or (5) send you materials and other helpful information and updates relating to BI Cares programs ("Services").

By signing below, you, the Prescriber, attest and certify that:

- The information provided in this Application and any additional information provided as part of the Application process is current, complete, and accurate to the best of your knowledge.
- To the best of your knowledge, the patient identified in this Application cannot afford the medication requested and (1) has no coverage or (2) has no coverage for the medication or (3) has coverage for the medication but has an out-of-pocket expense he/she cannot afford.
- You will not seek reimbursement for any medication dispensed from the Program.
- You will notify the Program immediately if the medication requested is no longer medically necessary for this patient's treatment or if you become aware that your patient's insurance or financial status has changed.
- You have a signed copy on file of your patient's current and completed HIPAA Authorization, or any other authorization or consent required by law, so that you may share patient health information with the Program, including BI Cares and its affiliates, agents, representatives and service providers.

In addition, by signing below, you, the Prescriber, understand and agree that:

- Any medication supplied as a result of this Application is for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit. No claims involving this medication shall be submitted to any third party (such as Medicare, Medicaid, Veterans Affairs or any other public programs) for reimbursement.
- Completing this Application does not guarantee that assistance will be provided to your patient.
- The information provided in this Application is subject to random audits and verification.
- BI Cares may change this program at any time and reserves the right to terminate your patient's enrollment at any time due to lack of eligibility or related factors.

X _____ _____

Prescriber Signature (Original – Stamps NOT ACCEPTED) Date