Patient Assistance Program Application

Arcutis Cares™

Arcutis Cares Patient
Assistance Program
c/o Carepoint Pharmacy
9 Commerce Drive
Schaumburg, IL 60173

Phone: 855-600-3755
Fax: 855-237-9113
arcutiscares.com

The Arcutis Cares Patient Assistance Program (the "Program") provides Arcutis medications at no cost for eligible patients.

If you qualify, enrollment is good for the benefit year of the requested medication to be dispensed through the Program.

Arcutis Cares does not charge patients a fee for its assistance and is not affiliated with third parties who charge a fee for assistance with enrollment or medication refills. The Program reserves the right to request additional information if needed and to change or discontinue the Program at any time, without notice.

How to apply

If you are the **Patient**, complete **Page 2** and **Page 3**.

- **Section 1:** Patient Information
- **Section 2:** Financial Information
  Please include proof of income for everyone in your household. We prefer your current tax return.
- **Section 3:** Insurance Information
  If you have insurance coverage, please attach a list of your current medical and prescription drug out-of-pocket costs. If you are taking multiple prescriptions, a printout from your pharmacy will be helpful. This information will help us review your eligibility for our Program.
- **Section 4:** Additional Permission for Program Purposes (Optional)
- **Section 5:** HIPAA Authorization
- **Section 6:** Patient Terms of Participation

Work with your **Healthcare Provider** to complete and submit **Page 4**.

- **Section 7:** Prescriber Information
- **Section 8:** Patient Information
- **Section 9:** Medication Request
- **Section 10:** Prescriber Certification and Signature

Please keep a copy for your records.

Meet the eligibility requirements

- Reside in and be treated by a healthcare provider in the United States
- Have a valid prescription for the Arcutis medicine consistent with the FDA-approved indication
- Be uninsured or government insured and unable to afford copayment. Commercially insured patients are not eligible
- Meet income guidelines, which vary by geography but start at 300% of the Federal Poverty Level, adjusted for family size

These are a few of the eligibility requirements for the Program. Meeting these requirements does not guarantee you will be accepted.

Submit application and required documentation

Work with your healthcare provider to complete all sections. Send the completed form and required documentation to Arcutis Cares as soon as possible so we can get you started in the Program.

By Fax:
855-237-9113

By Mail:
Arcutis Cares Patient Assistance Program
c/o Carepoint Pharmacy
9 Commerce Drive
Schaumburg, IL 60173

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To be completed by the patient or caregiver.

1 Patient Information

First Name | Last Name | DOB | Phone

Shipping Address (no PO box) | City | State | ZIP Code

2 Financial Information

$ _____
Monthly total income (for everyone in the household)

Total number of people in the household (including yourself)

Number in household over 18 years of age with income

- Please include a copy of your most recent federal tax return, or call for additional financial documentation options.

3 Insurance Information

☐ Check this box if you have NO insurance coverage. Go to **Section 4**.

- If you have insurance, please identify at right.
- Please include a detailed, current list of prescriptions, such as a pharmacy printout and medical expenses, for the household you would like us to consider.

ID/Policy #

PCN# (if known) | BIN# (if known)

Plan Name

Plan Address | City | State | ZIP Code

Private Insurance:	Yes ☐	No ☐
State Elderly Insurance:	Yes ☐	No ☐
Veterans Assistance:	Yes ☐	No ☐
Medicaid:	Yes ☐	No ☐
Medicare Prescription Drug Plan (Part D):	Yes ☐	No ☐

4 Additional Permission for Program Purposes (Optional)

I permit the Arcutis Cares Patient Assistance Program to speak with the following person about this application:

Name | Relationship | Phone

5 HIPAA Authorization

HIPAA Authorization

I authorize my healthcare providers, pharmacies, insurers, and laboratory testing facilities (my "Healthcare Team") to disclose information about me, my medical condition, treatment, insurance coverage, and payment information related to my use of Arcutis' medications (my "Information"), to the Arcutis Cares Patient Assistance Program (the "Program") so that the Program may determine my eligibility for and provide me with assistance and support in use of Arcutis' medications. I also authorize the Program to use my Information to (1) contact me and provide me with related services,

Continued on next page.

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5 HIPAA Authorization (Continued)

including referral to a separate private or public payer program, facilitating reimbursement and shipment of my medication; (2) perform research and data analytics to develop and evaluate products, services, materials, and treatments; (3) administer and maintain the quality of the Program, including by conducting case reviews, compliance checks, audit reviews and accounting functions; and to share my Information with my Healthcare Team for Program-related purposes.

I understand that, once my Information is released to the Program under this Authorization it will no longer be protected by the HIPAA privacy regulations, but I also understand that the Program intends to use and share my Information only as described in this Authorization.

I understand that I am not required to sign this Authorization and that my Healthcare Team will not condition my treatment or healthcare benefits on whether I sign this Authorization. However, I also understand that if I do not sign this Authorization, I cannot take part in the Program (should I qualify). This Authorization will expire in 10 years or a shorter period if required by state law, unless I cancel it sooner by calling the Program at 855-600-3755 or by writing to Arcutis Cares Patient Assistance Program c/o Carepoint Pharmacy, 9 Commerce Drive, Schaumburg, IL 60173. I understand that cancelling my Authorization will not invalidate any use or disclosure of my Information that occurred before my cancellation is received by the Program. I understand that I will receive a copy of this Authorization after I have signed it. My signature below certifies that I have read, understand, and agree to the terms of the HIPAA Authorization.

>> _____ _____

Signature of Patient or Legal Representative | Date

>> _____

Name of Patient or Legal Representative; if signed by Representative, state legal relationship to patient

6 Patient Terms of Participation

If I am enrolled in a Medicare plan including a Medicare Prescription Drug plan and I qualify for Program assistance, I will: (i) be eligible to obtain the medication from the Program through the end of the current calendar year term; (ii) not purchase this medication under my Medicare plan while enrolled in the Program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during my enrollment in the Program. I understand that if I am enrolled in a Medicare Part D Plan and am eligible for the Program, the Program will notify my Part D Plan of my enrollment.

I understand that completing this enrollment form does not guarantee that I will qualify for Program assistance. The Program may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by the Program shall not be sold, traded, bartered, or transferred. The Program reserves the right to change or cancel the Program, or terminate my enrollment, at any time. The support provided through this Program is not contingent on any future purchase.

If you have questions, want to update your information, or terminate your enrollment, please call 855-600-3755 or write to us at 9 Commerce Drive, Schaumburg, IL 60173.

☐ By checking this box, I acknowledge that I have provided accurate and complete information above and I understand and agree to the Patient Terms of Participation.

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Upon review of a completed application, we will notify the patient and the prescriber about eligibility. If approved, we will ship the prescription to the address provided for the patient. Refills will be provided based on medical necessity for on-label use as prescribed over the Program calendar year, subject to verification by the Program. Please call 855-600-3755 to request a refill or for additional assistance.

To be completed by your healthcare provider.

7 Prescriber Information

Prescriber Name | Designation (MD, OD, etc.) | NPI | State License

Office Name | Office Contact Name | Phone | Fax

Practice Address | City | State | ZIP Code

8 Patient Information

First Name | Last Name | Suffix

Date of Birth | Gender | Phone

Shipping Address (no PO box) | City | State | ZIP Code

9 Medication Request *(Must be completed by licensed prescriber)*

Product | ☐ Cream ☐ Foam Formulation | Strength | Quantity | Directions

ICD-10 | Refills | % Body Surface Area (BSA) Affected (optional)

Allergies | Other Medications

10 Prescriber Certification and Signature *(Prescriber, please sign and date below)*

I verify that the information provided is current, complete, and accurate to the best of my knowledge. I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party, including patient, nor will I sell, trade, or distribute any such medication. I also understand that the applicant's acceptance into the Program should not influence treatment decisions. I authorize the Program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Program for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

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Signature (Manual signature only – rubber stamps, signature by other personnel, or computer-generated images are not accepted) | Date

No fees apply to this Program.

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