Sucraid® (sacrosidase) Oral Solution

PAP Application Form

Patient Assistance Program

Need Help?
SucraidASSIST™
Phone: 1-800-705-1962
Fax: 1-866-777-7097
Email: sucraid@onepatientservices.com

INSTRUCTIONS: Please complete and fax this page to **1-866-777-7097 or email to sucraid@OnePatientServices.com**. Sucraid*ASSIST™* is provided by One Patient Services, LLC.

Do I Qualify for Assistance? To qualify for assistance, you must:

- Have been prescribed Sucraid® (sacrosidase) Oral Solution
- Live in the United States or a US territory
- Have no prescription coverage or not enough coverage to pay for Sucraid®
- Meet certain income limits (Income eligibility starts at 400% of the Federal Poverty Level and varies by household size. Income eligibility will be assessed upon receipt of your completed application.)

How Can I Apply? Please follow the checklist below when submitting your application:

- Fill out and sign the patient section of this enrollment form.

To be considered for the Patient Assistance Program (PAP), you will need the following:

- Completed and signed PAP application (this form)
- A photocopy of one of the following documents that shows your total annual household income:
  - Previous year's federal tax return (form 1040 or 1040EZ)
  - Wage and tax statements (W-2 forms)
  - Two recent paycheck stubs
  - Social security, pension, or railroad retirement statements (SSA-1099 or similar)
  - Statements of interest, dividends, or other income (1099-INT, 1099, 1099-DIV, or similar forms)

Make a photocopy of your application and income documentation (it may not be returned to you). Fax, mail, or email your application to:
Fax: **1-866-777-7097**, Mail: **One Patient Services, 3739 National Drive, Ste 100, Raleigh, NC 27612**, Email: **sucraid@onepatientservices.com**

If you need immediate assistance or have questions regarding any of the above, please call 1-800-705-1962.

Patient Information

Total Number of People Within Household (including applicant):	Total Annual Income for Entire Household:

Please submit documentation to support the financial information you've listed. Attached is:

☐ Most recent federal tax return ☐ W-2 form ☐ Other

Prescription Coverage and Insurance Information

Patient Privacy and Consent (Read and sign below)

The information you provide will be used by QOL Medical, Sucraid*ASSIST™*, and parties acting on their behalf to determine eligibility, to manage and improve QOL Medical's assistance programs, to communicate with you about your experience with QOL Medical's assistance programs, to help you understand your insurance coverage and help you access Sucraid® through your insurance, and/or to send you materials and other helpful information and updates relating to QOL Medical programs. By signing below, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge.

I understand that:

- Completing this application does not guarantee that I will qualify for QOL Medical assistance programs.
- QOL Medical may contact my insurer to help me understand my insurance coverage for Sucraid® and may provide me support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available).
- QOL Medical may verify the accuracy of the information I have provided and may ask for more financial and insurance documentation.
- Any medicines supplied by QOL Medical's assistance programs shall not be sold, traded, bartered, or transferred.
- QOL Medical reserves the right to change or cancel QOL Medical's assistance programs, or terminate my enrollment, at any time.
- The support provided through this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by QOL Medical through the QOL Medical Patient Assistance Program:

- I will promptly contact the QOL Medical Patient Assistance Program if my financial status or insurance coverage changes.
- I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses (TrOOP) for prescription drugs.
- I will not seek reimbursement or credit for the medicine(s) from my insurance prescription provider or payor, including Medicare Part D plans.
- I will notify my insurance provider of the receipt of any medications through the QOL Medical Patient Assistance Program.
- I have a signed copy of a current and completed HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with QOL Medical's assistance program and One Patient Services.
- I agree to be available to sign for delivery of the Sucraid® (sacrosidase) Oral Solution shipment.
- I must actively participate in Sucraid*ASSIST™* services including once per month telephone or email assessments, insurance reviews, and complete any required forms in a timely manner.

Patient First Name:	Last Name:
Patient Signature (or Caregiver):	Date:
Phone:	Email:
Relationship to Patient:	

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Enrollment Form

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HIPAA AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ("AUTHORIZATION")

Program Highlights (or Benefits): The SucraidASSIST™ program is designed to be the primary resource for Sucraid® (sacrosidase) Oral Solution patients, caregivers, and healthcare providers, where ASSIST stands for Access and Support Services in Sucraid® Therapy. One Patient Services offers the SucraidASSIST™ program that provides excellent customer service as well as peer and dietary support. One Patient Services is dedicated to improving patient outcomes by assisting customers with understanding their disease, drug, diet, and daily living with Sucraid®.

1. Authorization of Uses and Disclosures. HIPAA Authorization to Use and Disclose Protected Health Information ("Authorization"): 1. Authorization of Uses and Disclosures. I hereby authorize and direct my healthcare providers, health insurance company, US Bioservices Corporation (US Bio) or any other pharmacy, and their employees and agents as well as affiliated healthcare practitioners (collectively "Provider") to use and disclose my "protected health information" ("Information"), as described below, to (i) QOL Medical, LLC (QOL), the maker of Sucraid®; (ii) One Patient Services, LLC (OPS), Sucraid® support service provider; and (iii) QOL or OPS dietary consultants, patient assistance and other personnel, and any agent or representative of any of these parties (collectively "Authorized Parties"). **2. Description of Information.** I understand that my Information includes, but is not limited to, my name, date of birth, gender, and other personal information, contact information, and identifiers (including my address), medical information, including information about my health condition and related medical conditions, symptoms, treatments (including treatment relating to my past, present, and future use of Sucraid® and other healthcare items or services), diet, family medical history, medical records, and financial information (including information about my income, insurance coverage, and payment history) as well as other personal information collected by Provider and/or Authorized Parties about me. **3. Purposes.** I authorize and direct Provider to use and disclose my Information to Authorized Parties for the following purposes: (1) help address issues patient may incur in the prescription process; (2) provide me and my healthcare providers with educational materials, dietary information, and/or peer consultation; (3) conduct healthcare marketing activities, including those for which US Bio, QOL, or OPS receives compensation; (4) conduct clinical assessments regarding symptoms, therapeutic response to Sucraid®, and manner and adherence to treatment regimens; (5) determine potential qualification for patient assistance programs; (6) carry out any other purpose required or permitted by law; and (7) to contact me for additional information if needed. **4. Potential for Redisclosure.** I understand that once my Information is disclosed under this Authorization, it may be further disclosed and no longer protected by federal confidentiality laws, including HIPAA (a federal privacy law).
5. Treatment Not Conditioned; Signing Is Voluntary. I understand that treatment by my physician and Provider, payment by my insurance, or enrollment in my health plan is not conditioned upon the signing of this Authorization. However, if I refuse to sign this Authorization, my ability to receive support services related to my use of Sucraid® may be limited. I can choose not to sign this Authorization. **6. Expiration.** I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature, five (5) years following my discontinuance of purchase of Sucraid®, or as limited by state law unless I revoke it. **7. Revocation.** I understand that I have the right to revoke this Authorization by requesting in writing that this Authorization be revoked by sending written notice to the OPS Manager at One Patient Services, 3739 National Drive, Ste 100, Raleigh, NC 27612. If I revoke this authorization, the pharmacy will stop using and disclosing my Information. However, my revocation will not affect any prior use or disclosure of Information made in reliance on this Authorization and my revocation will not affect my treatment by my physician.
8. Questions. If I have questions about disclosures of my Information, I may contact the Privacy Officer at OPS at sucraid@onepatientservices.com. **9. Copy.** I understand that I will be provided with a copy of this Authorization.
I hereby certify that I am over the age of 18 and I have read this document and fully understand the contents.

Patient First Name:	Last Name:
Gender: ☐ Male ☐ Female	DOB: / /
Patient Signature (or Caregiver):	Date:
Phone:	Email:
Relationship to Patient:	

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