ABSORICA®
isotretinoin capsules
WITH LIDOSE™ TECHNOLOGY

PATIENT ASSISTANCE PROGRAM

APPLICATION

If your patients meet eligibility requirements, the ABSORICA® Patient Assistance Program may be able to provide them with a free monthly supply of medication.* The medication will be sent directly to each patient's home or an alternative shipping address of choice with packages requiring a signature at the time of delivery.

Prescribers are required to complete this form in its entirety with their patient, as well as sign and fax the form and any supporting documents to the Patient Assistance Program at 866-810-3258.

Please see page 2 for eligibility guidelines.

FOR MORE INFORMATION ABOUT THE PROGRAM,
VISIT ABSORICA.COM/financialassistance
or call the Patient Assistance Program
at 833-SKIN-HLP (833-754-6457)
9:00 AM to 5:30 PM EST, Monday-Friday

*This Patient Assistance Program is not a government program or insurance plan. If a patient qualifies, he or she may receive free medication on an as-needed basis (as determined by physician prescription and program rules) as long as he or she meets program requirements.

Please see FULL PRESCRIBING INFORMATION, including BOXED WARNING and MEDICATION GUIDE FOR ABSORICA.

HOW TO ENROLL A PATIENT IN THE ABSORICA PATIENT ASSISTANCE PROGRAM

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1. **COMPLETE** this form in its entirety with your patient.
2. **SIGN AND DATE** the form.

IMPORTANT: Stamped signatures are allowed, but in some cases, original signatures may be required.

3. **FAX** the completed, signed form with the appropriate supporting information to 866-810-3258, based on the following patient insurer status:
   - **NO INSURANCE:** Fax the completed, signed form and proof of income
   - **FINANCIAL HARDSHIPS:** Fax the completed, signed form; proof of income; and supporting documentation explaining changes in circumstances (ie, loss of employment, change in marital status)

IMPORTANT: Proof of income should be in the form of **1)** the previous year's federal income tax returns for the patient, spouse, and dependents OR **2)** all income statements from the patient's employer (W2 or 1099) OR **3)** the patient's Social Security Income Yearly Benefits Statement.

WHAT TO EXPECT AFTER ENROLLMENT

If your patient qualifies, he or she may be enrolled for up to 6 months. Upon enrollment, a program representative will notify you and your patient. A 30-day supply of ABSORICA will be delivered to your patient at no cost to him or her. Each month, a program representative will confirm with you and your patient that he or she is still being treated, following the iPLEDGE® Program requirements, and eligible to receive another month's supply of medication.

ELIGIBILITY GUIDELINES

Eligibility is subject to each patient's current status. Eligibility reverification will be completed every 5 to 6 months (based on a 5-month treatment regimen).

Patients may qualify for the ABSORICA Patient Assistance Program if the patient:

- Does not have existing drug coverage for the prescribed product under any prescription drug benefit, including private insurance, Medicare, Medicaid, or other government insurance programs or the patient is in the 90-Day Waiting Period for Medicare coverage
- Is a US resident (including Puerto Rico) or a Green Card or work visa holder
- Has an income at or below 400% of the federal poverty level
- Is registered with the iPLEDGE Program by his or her prescriber

If the patient has insurance, the patient can be enrolled in this Patient Assistance Program if:

- Coverage is terminated
- Product is not covered
- Hardship exemption
- No prescription coverage
- Emergency only
- Discount card only
- Exceeded annual cap
- Generic coverage only
- Product non-formulary

Eligibility guidelines are subject to change. Sun Pharma reserves the right to change, rescind, or revoke its Patient Assistance Program at any time.

IF YOU THINK YOUR PATIENT QUALIFIES FOR THE ABSORICA PATIENT ASSISTANCE PROGRAM, please complete, sign, and fax pages 3 and 4 of this form to 866-810-3258.

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PATIENT INFORMATION

Name: _____ Date of Birth: ____ / ____ / _____ (mm/dd/yyyy)
First Middle Initial Last

Address: _____ City: _____ State: _____ ZIP: _____

Phone: (_____) _____-_____ Gender: ☐ Male ☐ Female

Social Security number: ____-___-____

If you don't have a Social Security number, you must provide one of the following *(select one):*

☐ Green Card number: _____
☐ Confirmation letter from the government stating a US Green Card application has been submitted
☐ Work visa number: _____

TREATMENT HISTORY

Previous treatments, if any: _____

INCOME

Number of people in household: _____
(include you, spouse, and dependents)

Total combined household income: $ _____ monthly *or* $ _____ yearly
(include you, spouse, and dependents)

NOTE: You (the patient) will need to provide proof of income. Please be sure to fax proof of income with this form.

INSURANCE

Do you have any form of prescription drug coverage?

☐ Employer-furnished or private drug coverage
☐ Medicaid
☐ Medicare Part A
☐ Medicare Part B
☐ Medicare Part D
☐ VA or military benefits
☐ State assistance program for medicine
☐ None

PATIENT ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

The Sun Pharma ABSORICA Patient Assistance Program must have the patient's authorization to determine eligibility for patient assistance and to conduct insurance research. By signing below, I authorize Sun Pharmaceutical Industries, Inc.("Sun Pharma") and/or its affiliates, and EnvoyHealth and/or its affiliates ("EnvoyHealth") to contact me, my insurer(s), and physicians, and authorizes my insurer(s) to disclose to EnvoyHealth my Protected Health Information, as defined within 45 C.F.R. § 160.103, including but not limited to medical records and treatment, health insurance coverage, my name, address, telephone number, insurance plan, and/or group numbers. Furthermore, I authorize EnvoyHealth to provide the insurer(s), including Medicare, with my name, date of birth, Social Security Number, diagnosis, insurance information or other relevant information about me. By signing below, I also attest that the financial information I have provided is complete and accurate and agree that EnvoyHealth may verify this information. I understand that my choice about whether to sign this Attestation and Authorization for Release will not change the way my healthcare providers or insurer(s) treat me. I also may revoke (withdraw) this authorization at any time in the future by sending a written notice to EnvoyHealth, 325 W. Atherton Rd., Flint, MI 48507, or by calling 833-SKIN-HLP (833-754-6457). I understand that once my Protected Health Information is disclosed, it will no longer be protected by federal privacy law as Protected Health Information and may be re-disclosed. I acknowledge that Sun Pharma reserves the right to change or revoke this program at any time. By signing below I authorize EnvoyHealth to contact me directly about available assistance programs, treatments and therapies and/or reimbursement and access related information and I acknowledge and agree that EnvoyHealth may receive compensation for such communications.

Patient Signature: _____ **Date:** _____
(If patient cannot sign, patient's legally authorized representative must sign.)

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PRESCRIBER INFORMATION

Prescriber's Name:_____ Phone: (____)_____-_____

NPI #: _____ Fax: (____) _____-_____

Address: _____

City: _____ State: _____ ZIP: _____

ENROLLMENT IN THE iPLEDGE® PROGRAM

The iPLEDGE Program is a computer-based risk management program designed to further the public health goal of eliminating fetal exposure to isotretinoin through a special restricted distribution program approved by the FDA. The program strives to ensure that no female patient starts isotretinoin therapy if pregnant and no female patient on isotretinoin therapy becomes pregnant.

To receive therapies containing isotretinoin, female patients of reproductive potential must be enrolled in the iPLEDGE Program by their physician. The iPLEDGE Program is a set of steps all patients, doctors/prescribers, and pharmacists must follow. The main goal is preventing pregnancy and birth defects, and both male patients and female patients must participate in the iPLEDGE Program to receive therapy containing isotretinoin.

IF YOUR PATIENT IS A MALE, PLEASE ANSWER THE FOLLOWING QUESTION:

The patient has understood the risks and benefits of ABSORICA, complied with the requirements of the iPLEDGE Program described in the booklet entitled *The iPLEDGE Program Guide to Isotretinoin for Male Patients and Female Patients Who Cannot Get Pregnant*, and signed a Patient Information/Informed Consent form.

☐ Yes ☐ No *Male patients must obtain a prescription within 30 days of the office visit.*

IF YOUR PATIENT IS A FEMALE, ANSWER THE FOLLOWING QUESTIONS:

My patient is of reproductive potential.

☐ Yes ☐ No

If answered "No" to the above question, please answer the following:

The patient has understood the risks and benefits of ABSORICA, complied with the requirements of the iPLEDGE Program described in the booklet entitled *The iPLEDGE Program Guide to Isotretinoin for Male Patients and Female Patients Who Cannot Get Pregnant*, and signed a Patient Information/Informed Consent form.

☐ Yes ☐ No *Female patients of nonreproductive potential must obtain a prescription within 30 days of the office visit.*

If answered "Yes" to the above question, please answer the following:

My patient is not pregnant.

☐ Yes ☐ No

The patient has understood the risks and benefits of ABSORICA, complied with the requirements of the iPLEDGE Program described in the booklets entitled *The iPLEDGE Program Guide to Isotretinoin for Female Patients Who Can Get Pregnant* and *The iPLEDGE Program Birth Control Workbook* (including the pregnancy testing and contraception requirements), and signed a Patient Information/Informed Consent form.

☐ Yes ☐ No

The patient agrees to answer questions about the iPLEDGE Program and pregnancy prevention monthly.

☐ Yes ☐ No *Female patients of reproductive potential must obtain the prescription within 7 days of taking a pregnancy test.*

ABSORICA PRESCRIPTION INFORMATION

Patient Name:_____ Date of Birth ____/____/____ (mm/dd/yyyy)

Patient Weight *(in pounds)*: _____ ICD-10 Code:_____

PLEASE SELECT THE FOLLOWING PRESCRIBED DOSAGE BASED ON YOUR PATIENT'S WEIGHT.

Recommended dosage of 0.5 mg to 1 mg/kg/day given in 2 divided doses without regard to meals for 15 to 20 weeks.

ABSORICA is filled for a 30-day supply with a Medication Guide. Refills will require a new prescription and a new authorization from the iPLEDGE system.

STRENGTH	SIG	QUANTITY*
☐ 10-mg capsules	BID	30 capsules
☐ 20-mg capsules	BID	30 capsules
☐ 25-mg capsules	BID	30 capsules
☐ 30-mg capsules	BID	30 capsules
☐ 35-mg capsules	BID	30 capsules
☐ 40-mg capsules	BID	30 capsules

BID=twice a day.
*ABSORICA must only be dispensed in no more than a 30-day supply.

Prescriber Signature: _____ **Date:** _____

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