Waylis Patient Access & Affordability

Patient Assistance Program

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PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application must be completed, signed and dated by both the Healthcare Professional and Patient.
- Patient must submit one of the following pieces of Proof of US Residency documentation:
  1. A valid driver's License or state issued ID card
  2. Passport
  3. Veteran or active military ID card
  4. Social security benefit letter

- Patient must submit one of the following pieces of Proof of Income documentation:
  1. Active Medicaid coverage letter obtained from Medicaid plan or physician's Medicaid eligibility portal.
  2. Federal Income Tax (form 1040 or 1040EZ) with appropriate schedule (C and/or F)
  3. Federal Income Tax Form 1099
  4. Yearly benefits statement (SSA, 1099, etc.)
  5. Bank statements showing automatic deposit for the current calendar year
  6. Minimum of 3 most current pay stubs

ELIGIBILITY & REQUIREMENTS

- The medication cannot be covered by a Commercial or Government funded insurance plan.
- Patient's annual household income must be at or below 500% of the current Federal Poverty Level.
- Patient must be a resident of the US or US territories.

GENERAL PROGRAM INFORMATION

- The requested medication can be shipped to the patient's home or prescriber's office upon request.
- Patient Assistance Program (PAP) enrollment is only available to patients who meet program eligibility requirements AND their private or government funded insurance plan doesn't cover the medication at issue.
- Before the patient is due for yearly renewal, the Healthcare Professional and the Patient must sign and submit a new application. For assistance with program enrollment, please contact the WAYLIS Patient Assistance program at:

(888) 218-8897

PATIENT CHECKLIST

✓	Patient or Patient Caregiver provided complete information as requested in STEP 1 and Step 2.	**YES**	**NO**
✓	Patient or Patient Caregiver has and will supply required proof of income documentation.	**YES**	**NO**
✓	Patient or Patient Caregiver has and will supply required proof of US residency documentation.	**YES**	**NO**
✓	By signing the application, I certify that I have read and agreed to the terms of the patient declaration on page 5.	YES	NO

- If "NO" to proof of income, please contact the WAYLIS Patient Assistance Support program at:

(888) 218-8897

HEALTHCARE PROFESSIONAL CHECKLIST

✓	Healthcare Professional provided complete information as requested in STEP 3 and STEP 4.	**YES**	**NO**
✓	By signing the application, I certify that I have read and agree to the terms of the Physician Authorization on page 5.	**YES**	**NO**

Waylis Patient Access & Affordability

Patient Assistance Program

Phone: (888) 218-8897 ■ Fax: (844) 470-1931

STEP 1 – PATIENT INFORMATION – TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

Patient First Name: MI: Patient Last Name:

Address: City: State: Zip:

Date of Birth: (MM/DD/YYYY) Gender: Male Female Patient Weight: lbs kg

Primary Phone: Email: Marital Status: S M W D

Are you a U.S. Resident? Y N Are you a Veteran? Y N Are you Disabled? Y N

Gross Annual Household Income: Number of Persons in Household:

Contact Name: (if other than patient) Relationship to Patient:

Proof of Income Documentation is required for this program. Please select the documents you intend to submit:

Federal Tax Return Social Security Income Bank Statements/Paycheck Stubs (minimum of 3)

Medicaid Coverage Letter Other:

STEP 2 – PATIENT INSURANCE INFORMATION – TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

What type of insurance coverage do you have? ***NO ACTIVE INSURANCE COVERAGE?*** *(Check Here)*

Medicare Part A/B Medicare Part D Medicare Advantage

Medicaid Employer/ Commercial Plan Other:

For each insurance policy, you have, please attach a copy of both the front and back of your insurance card and fill in the following:

Primary Insurance Name: Secondary Insurance Name:

Phone Number: Phone Number:

Policy ID: Policy ID:

Group Number: Group Number:

I certify that the information in Sections 1 and 2 above, as well as on the attached patient declaration page are complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize Waylis Therapeutics Inc. to obtain and disclose information from physicians, insurance companies and others as necessary to verify the information provided on this application.

Patient Signature: Date: / /

STEP 3 – PROFESSIONAL INFORMATION – TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR OFFICE

DEA Number: (if applicable) NPI Number: State License Number:

Physician First Name: Physician Last Name:

Office Address: Office Main Phone #: Office Fax #:

Office Contact Name: Office Contact Phone: Office Email:

Medication Shipping Preference (Check One): **PATIENT HOME **MD OFFICE** **OTHER**

**MEDICATION SHIPPING ADDRESS:

STEP 4 – PRESCRIPTION INFORMATION – THIS IS THE PRESCRIPTION; NO ADDITIONAL PRESCRIPTION IS NEEDED

MEDICATION NAME	RX DIRECTIONS	QUANTITY	REFILLS
Humatin 250mg Capsule			0 1 2 3 4 5

I certify that the information in STEPS 3 & 4 on this page, as well as the attached Physician Authorization page is complete and accurate to the best of my knowledge. I understand that additional information may be requested to process this application, but that all information will be kept confidential, except otherwise required by law. I hereby authorize Waylis Therapeutics Inc. to obtain and disclose information from insurance companies and others as necessary to verify the information provided on this application.

Physician Signature: Date: / /

 Upon completion of this form, please fax to the Waylis Access & Affordability Program at: (844) 470-1931.