

The Nestlé Pharmaceutical Patient Assistance Program (PAP) supports eligible patients who meet program criteria in obtaining prescribed medication. Approved patients may receive Zenpep® (pancrelipase) delayed-release capsules and Viokace® (pancrelipase) tablets at no cost to them during the enrollment period, subject to program terms, eligibility criteria, and verification.

Approved patients may receive up to 12 months of eligibility. Prescription medication will be shipped directly to the patient at the address provided.

Processing times may vary depending on application completeness and verification requirements.

The program is not insurance and does not replace or affect any insurance coverage. The program may be modified or discontinued at any time without notice.

### Checklist for Submitting an Application

All sections of the application must be completed to be considered for the program.

#### IF YOU ARE A PATIENT

- Refer to Page 3: complete Patient Information, Income Information, and Coverage Information
- Refer to Page 5: sign and date Patient Certification
- Refer to Page 6: sign and date Patient Authorization
  - *Your signature and date will be valid for 12 months*
- **Provide proof of income (eg, federal tax return, W-2, current pay stubs) for the entire household.**
  - Other documents for the application may include a monthly healthcare benefits statement or Social Security award letter or bank statement showing a monthly direct deposit (Social Security, Veterans Affairs [VA])
  - Self-employed patients must attach a copy of their most current federal income tax statement with appropriate schedules (C and/or F) attached
  - If you have no income, a letter from your physician or social worker (on their letterhead) is required. The letter must affirm your financial situation
- For patients unable to sign the application, the power of attorney (POA) should include their notarized POA form
- For patients with Zenpep and Viokace medications that are reimbursed under a Medicare Part D prescription drug plan with income below 150% of the federal poverty level (FPL), you may qualify for the “Medicare Prescription Drug Plan Extra Help” program, also known as “Extra Help” or “Low-Income Subsidy.” Patients with Medicare and income below 150% FPL must have applied and been denied for the Extra Help program to be eligible for Zenpep and Viokace PAP. Please include the Extra Help denial letter with your PAP enrollment

For more information on the Extra Help program, along with how to apply for the Extra Help program, visit <https://www.medicare.gov/basics/costs/help/drug-costs> or call 1-800-772-1213.

- In the case that a PAP product needs to be returned for any reason, please call the PAP phone number for instructions: 1-855-210-6228

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Visit <https://www.nestlehealthscience.us/patient-assistance-program> for additional information.  
For Nestlé Health Science’s Privacy Policy, see <https://www.zenpep.com/privacy-policy>.  
For Terms of Use, see <https://www.nestlehealthscience.us/info/terms-of-use>.

### IF YOU ARE A PRESCRIBER

- Refer to Page 4: complete Licensed Prescriber Information
  - *Note: Include medication, dosage, and quantity requested in this section*
- Sign and date Licensed Prescriber Certification
  - *Your signature and date will be valid for 12 months*

**Fax or mail the completed application and documentation to:**

**Nestlé Pharmaceutical Patient Assistance Program**  
**PO Box 66520**  
**St. Louis, MO 63166**  
**Phone: 1-855-210-6228**  
**Fax: 1-877-867-1831**

Upon receipt of a completed application, notification of eligibility/ineligibility will be sent to the prescriber and patient. If the medication is approved, we will ship the medication(s) directly to the patient at the address provided on the application. Please allow 4 weeks for application processing and delivery of medication(s). Incomplete applications may be returned to the applicant or prescriber with instructions for completion. Please contact us at 1-855-210-6228, Monday through Friday, 8 AM – 5 PM CST for assistance.

Visit <https://www.nestlehealthscience.us/patient-assistance-program> for additional information.  
For Nestlé Health Science's Privacy Policy, see <https://www.zenpep.com/privacy-policy>.  
For Terms of Use, see <https://www.nestlehealthscience.us/info/terms-of-use>.



**PATIENT INFORMATION** (All information noted with an \* is required information)

*First Name		*Last Name	
*Street Address			
*City		*State	*ZIP Code
*Date of Birth (mm/dd/yy)		*Primary Phone <input type="checkbox"/> Home <input type="checkbox"/> Mobile	
Email		*U.S Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
*Number of People in Household (Including Patient)		Marital Status	

**INCOME INFORMATION** (Please attach proof of income to this application.)

Salary/Wages: \$	Social Security: \$
Alimony/Child Support: \$	Disability: \$
Pension/Retirement: \$	Unemployment/Work Comp: \$
Other: \$	*Total Gross Monthly Household Income: \$

**INSURANCE INFORMATION**

*Veterans Affairs (VA) Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Are you enrolled in Medicare Part A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Are you enrolled in a Medicare Advantage Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Are you enrolled in a Medicare Part D Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare ID Number
Do you have private prescription coverage/reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Example: Through your employer, the healthcare marketplace or non-government sponsored plan.)</i>	
<b>Please provide the following information regarding your primary insurance plan:</b>	
*Plan Name	*Policyholder Name
*Policy ID Number	*Group Number
<b>What Is the Insurance Copay/Out-of-Pocket Expense for the Requested Medication? \$</b>	
If You Were Denied Medicare Extra Help, Did You Attach the Denial Letter? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**PATIENT INFORMATION** (All information noted with an \* is required information)

*Patient Name	*Date of Birth (mm/dd/yy)
*Patient Address	

**LICENSED PRESCRIBER INFORMATION**

*Prescriber First Name	* Prescriber Last Name	
*Prescriber NPI	State License Number	
*Facility Name		
*Street Address		
*City	*State	*ZIP Code
Contact Name		
*Phone	*Fax	

**PRESCRIPTION INFORMATION**

Allergies			
Current Medications			
*Medication (Check One):	<b>Day's Supply</b>	<b>Directions</b>	<b>Refills</b>
Zenpep® (pancrelipase) delayed-release capsules	<input type="checkbox"/> 3,000 USP <input type="checkbox"/> 20,000 USP <input type="checkbox"/> 5,000 USP <input type="checkbox"/> 25,000 USP <input type="checkbox"/> 10,000 USP <input type="checkbox"/> 40,000 USP <input type="checkbox"/> 15,000 USP <input type="checkbox"/> 60,000 USP	<input type="checkbox"/> 90-day  <i>Dispensed in 100 count bottles rounded up to ensure full 90-day supply.</i>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Viokace® (pancrelipase) tablets	<input type="checkbox"/> 10,440 USP <input type="checkbox"/> 20,880 USP	<input type="checkbox"/> 90-day  <i>Dispensed in 100 count bottles rounded up to ensure full 90-day supply.</i>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

**LICENSED PRESCRIBER CERTIFICATION**

I certify that the use of the medication listed above is medically necessary and appropriate for the individual listed above ("Patient"), the Product will only be used for this Patient, and I will be supervising the Patient's treatment accordingly. I further certify that, to the best of my knowledge, this Patient has insufficient financial resources to pay for the prescribed therapy.

I agree not to bill or collect from the Patient or any government or private payer, or to trade, sell, barter for, or return for credit any Product provided under the Program.

I attest that I have obtained written permission, in the event it is required under applicable federal and/or state law, of my patient (or the patient's legal representative) for release of my patient's Protected Health Information ("PHI") to Nestlé Health Science and any third party engaged to assist Nestlé Health Science in administering the Patient Assistance Program (the "Program") (collectively, "Nestlé Health Science") for the purposes described herein.

I understand I am to comply with the state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. I agree that Nestlé Health Science may contact me for additional information relating to Product, including but no limited to email, fax, and telephone.

For the purposes of transmitting this prescription, I authorize Nestlé Health Science and its affiliates, business partners, and agents to, for these limited purposes, forward this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

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 \*Dispense as written Prescriber Signature (No stamps)    Date (MM/DD/YYYY)    \*Substitution allowed Prescriber Signature (No stamps)    Date (MM/DD/YYYY)

**SECTION 3.0: PATIENT CERTIFICATION**

I certify that all information provided on Page 3 is correct and complete to the best of my knowledge, and I acknowledge that I have an obligation to update Nestlé, using the contact information herein, of any changes in my financial status or insurance coverage.

Any drug provided to an eligible applicant under this program will be free of charge. There is no purchase requirement associated with receiving assistance under this program.

I understand that Nestlé Health Science, including any agents that Nestlé Health Science engages to administer or otherwise support the Patient Assistance Program (the “Program”) (collectively, “Nestlé”), may contact me to request verification of any information provided or requested on this form, which I agree to provide personally or through my employer or my insurance or other benefits provider. Completion of this form does not guarantee approval for the Program.

If approved, I certify that:

- (i) I will not seek reimbursement for any drug(s) requested on the prescription attached to this application from any government program or third-party payer;
- (ii) If I am a member of a Medicare Part D plan, I will not apply or claim the cost of any Program drug(s) toward my true out-of-pocket costs;
- (iii) I will notify my insurance or other benefits provider of my receipt of any drug(s) through the Program, if required to do so by those providers;
- (iv) I understand that the Program does not affect any administration fees my prescriber may charge in accordance with his or her normal billing policies; and
- (v) I understand that I will receive a 3-month supply of drug(s), unless my provider has prescribed refills for up to 12 months. I must reapply after 12 months of being approved for the Program or at the end of the calendar year if I am covered by a government program. My prescriber must submit additional prescriptions if additional drug(s) are requested.

I understand that Nestlé Health Science reserves the right, at any time and without notice to me, to modify and/or discontinue any part(s) or all of the Program, including modifying eligibility criteria and/or covered medications, and immediate termination of assistance provided by the Program.

Patient Printed Name	
Patient/Legal Representative Signature:  <b>X</b>	Date:
If Legal Representative, Print Name and Indicate Relationship:	

**SECTION 4.0: PATIENT AUTHORIZATION**

By signing below, I hereby authorize my prescriber, pharmacy, or other healthcare provider set forth above to disclose and transmit my Protected Health Information (“PHI”) (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, as amended) to Nestlé Health Science and any third party engaged to assist Nestlé Health Science in administering the Patient Assistance Program (the “Program”) (collectively, “Nestlé Health Science”) for the purposes described herein.

I understand that Nestlé Health Science may disclose and transmit my PHI to my insurance or other benefits provider, including the Centers for Medicare & Medicaid Services (“CMS”) and any authorized vendor(s) of such insurance or other benefits providers, for the purposes of verifying my Medicare Part D or other enrollment status, confirming my coverage (or lack thereof) for the requested drug(s), and disclosing my enrollment in the Program with my Medicare Part D plan or other insurance/benefits provider.

I understand that my PHI may include my name, address, income, prescription coverage, prescription for drug(s), financial documents and insurance records, other information provided on this application form, and any information reasonably requested by Nestlé Health Science for the purposes of (i) determining my eligibility to participate in the Program, both initially and throughout my participation in the Program; (ii) shipping appropriate drug(s) as prescribed by my licensed prescriber; and (iii) administering, evaluating, and improving the Program.

I understand that signing this authorization does not guarantee that I will be accepted into the Program. I further understand that because Nestlé Health Science is not covered by federal privacy regulations, after my information is disclosed to Nestlé Health Science, it will no longer be protected under federal law and could be subject to redisclosure. This authorization will expire one (1) year from the date of my signature below, as required by law, or upon execution of a new authorization pursuant to reapplication to the Program.

I may revoke this authorization at any time by providing written notice to Nestlé Health Science at the address set forth above. My revocation will become effective on the date my written notice is received and processed by Nestlé Health Science. If I revoke my authorization, I understand this means I may no longer be able to receive assistance from the Program. I also understand that I may refuse to sign this authorization and that doing so will not affect my prescriber’s treatment of me or my eligibility for insurance benefits. I also understand I have a right to receive and/or make a copy of this authorization.

Patient Printed Name	
Patient/Legal Representative Signature:  <b>X</b>	Date:
If Legal Representative, Print Name and Indicate Relationship:	