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

The Zenpep and Viokace Patient Assistance Program (PAP) provides Zenpep® (pancrelipase) delayed-release capsules and Viokace® (pancrelipase) tablets at no cost to eligible patients. If the patient qualifies, they can receive up to twelve-months eligibility for the requested medication(s) or device(s) is approved for shipment to the **patient's licensed prescriber for dispensing**.

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 2: Complete the Patient Information, Income Information, and Coverage Information.
- Refer to Page 3: Sign and Date Patient Certification.
- Refer to Page 4: Sign and Date Patient Authorization.
    - *Your signature and date will be valid for 12 months*
- **Provide proof of income (examples include federal tax return, W-2, or current pay stubs) for the applicant.**
    - Other documents for the application may include: Monthly healthcare benefits statement, Social Security award letter or bank statement showing monthly direct deposit (Social Security, Veterans Affairs).
    - Self-Employed patients must attach a copy of the 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 is required on their letterhead. The letter must affirm patient's 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, known as "Extra Help" or "Low-Income Subsidy". Patients with Medicare and income below 150% FPL must apply and have 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

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IF YOU ARE A PRESCRIBER

- Refer to Page 2: Complete the Licensed Prescriber Information.
  - *Note: Include Medication, Quantity and Dosage requested in this section.*
- Refer to Page 5: Sign and Date Licensed Prescriber Certification.
  - *Your signature and date are valid for 12 months.*
- In the case that a PAP product needs to be returned for any reason please call the Patient Assistance Program Phone Number - 855-210-6228 for instructions.

Fax or mail the completed application and documentation to:

- **Zenpep and Viokace 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 will be sent to the prescriber and patient. If approved, we will ship the medication to the licensed prescriber indicated on the application. Please allow 4 weeks for application processing and delivery of medication. 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 US CST for additional assistance.

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SECTION 1.0 LICENSED PRESCRIBER INFORMATION

Prescriber Full Name and Designation:

State License Number:

DEA Number:	NPI Number:

Contact Name:

Phone:	Fax:

Prescriber Shipping Address:

Medication (check one):	Days supply (check one):	Quantity:
Zenpep® (pancrelipase) ☐ 3,000 USP ☐ 15,000 USP ☐ 40,000 USP ☐ 5,000 USP ☐ 20,000 USP ☐ 60,000 USP ☐ 10,000 USP ☐ 25,000 USP	☐ 30-day ☐ 90-day	
Viokace® (pancrelipase) ☐ 10,440 USP ☐ 20,880 USP		

SECTION 2.0 PATIENT INFORMATION

Patient Full Name:

Phone Number:	Gender:
Date of Birth:	Marital Status:

Mailing Address:

Email Address:

Number of people in household (including self):

Are you a veteran: Yes ☐ No ☐	Are you a US Citizen: Yes ☐ No ☐

SECTION 2.1 INCOME INFORMATION

Salary/Wages: $	Social Security: $
Alimony/Child Support: $	Disability: $
Pension/Retirement: $	Unemployment/Work Comp: $
Other: $	**Total Household Gross Monthly Income**: $ (Please attach proof of income to this application)

SECTION 2.2 COVERAGE INFORMATION

VA or Military Benefits: Yes ☐ No ☐	Are you enrolled in Medicaid: Yes ☐ No ☐
Medicare ID#:	Are you enrolled in Medicare: Yes ☐ No ☐
	Are you enrolled in Medicare D Plan: Yes ☐ No ☐

Do you have private prescription coverage/reimbursement: Yes ☐ No ☐

Please provide the following information regarding your primary insurance plan.

Plan Name:

Policy Holder Name:

Policy ID Number:

Group Number:

What is the co-pay/out of pocket expense for the requested medication:

Has your insurer denied coverage for the requested medication? Yes ☐ No ☐

If denied Medicare Extra Help, did you attach denial letter? Yes ☐ No ☐

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SECTION 3.0: PATIENT CERTIFICATION

I certify that all information provided in sections 2.0, 2.1 and 2.2 is correct, complete to the best of my knowledge, and 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 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 benefit 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) and/or device(s) requested on the prescription attached to this application from any government program or third-party payor;

(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) and/or device(s) toward my true out-of-pocket costs;

(iii) I will notify my insurance or other benefit provider of my receipt of any drug(s) and/or device(s) through the Program, if required 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 my prescriber will receive a three-month supply of drug(s) or device(s) to dispense to me, that my prescriber must submit additional prescriptions if additional drug(s) or device(s) are requested, and that 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.

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

Patient/Legal Representative Signature: **X**	Date:
If Legal Representative, Print Name and Indicate Relationship:	

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SECTION 4.0: PATIENT AUTHORIZATION

By signing below, I hereby authorize my prescriber, pharmacy or other health care provider set forth in Section 1.0 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 benefit provider, including the Centers for Medicare & Medicaid Services ("CMS") and any authorized vendor(s) of such insurance or other benefit providers, for the purposes of verifying my Medicare Part D or other enrollment status, confirming coverage (or lack thereof) for the requested drug(s) and device(s), and disclosing my enrollment in the Program with my Medicare Part D plan or other insurance/benefit provider.

I understand that my PHI may include my name, address, income, prescription coverage, prescription for drug(s) or device(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) and/or device(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 re-disclosure. 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 by 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/Legal Representative Signature: **X**	Date:
If Legal Representative, Print Name, and Indicate Relationship:	

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SECTION 5.0: LICENSED PRESCRIBER CERTIFICATION

This Program aids financially eligible patients who need Product(s). Patients who are uninsured or underinsured and are unable to afford the cost of therapy may be eligible for enrollment. While Nestlé Health Science makes every effort to grant aid when needed and appropriate, the Program is limited in available resources and may be discontinued or modified at any time, without further notice.

I certify that the use of the medication listed in Section 1 above ("Product") is medically necessary and appropriate for the individual listed in Section 2 above ("Patient"), the Product will only be used for this Patient, and that I will be supervising the Patient's treatment accordingly. I further certify that, to the best of my knowledge, this Patient has no medical insurance coverage for Product, including Medicaid/Medicare or other government programs, and the 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. While I agree that I will not seek payment for an office visit from the Patient or a third-party payor when the only service provided at such office visit is provision of the Product(s) to the Patient, I also certify that my Patient understands that he/she is responsible for the costs of administering Product if I am unable to waive the administration fee.

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

Licensed Prescriber's Signature: **X**	Date:
Prescriber's NPI Number:	