MERZ CONNECT™

Contact the MERZ CONNECT™ Support Line
1-844-4MYMERZ (1-844-469-6379), option 4
Monday – Friday 8am – 7pm ET
Fax 1-855-825-0488

XEOMIN® incobotulinumtoxinA

XEOMIN Patient Savings Program Enrollment Form

1 PROGRAM ELIGIBILTY QUESTIONS

☐ Yes ☐ No Does the patient have commercial insurance?

☐ Yes ☐ No Is the patient at least 2 years of age and younger than 65 years of age?

☐ Yes ☐ No Is the patient currently a resident of the United States, Puerto Rico, or other US territories?

☐ Yes ☐ No Does the patient live in Massachusetts or Rhode Island ? *(Restrictions apply.)*

☐ Yes ☐ No Is the patient eligible for, or covered by any state or federally funded prescription insurance program, such as Medicare Part D, Part B, Medicaid Medigap, Veterans Affairs (VA), Department of Defense (DOD) programs, or TriCare?

2 PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____ MI ____

Date of Birth (MM/DD/YYYY) _____ Gender ☐ M ☐ F

Street Address _____ City _____ State _____ Zip _____

Preferred phone # _____

Legal Guardian Name _____ Relationship to Patient _____

Legal Guardian Phone _____ Patient/Legal Guardian Email *(Required)* _____

3 COMMERCIAL INSURANCE

PRIMARY Insurance Name _____ Phone Number _____

Policy holder _____ Policy holder ID # _____ Group ID # _____

Policy holder Date of Birth (MM/DD/YYYY) _____ Policy holder's Relationship to Patient _____

SECONDARY Insurance Name _____ Phone Number _____

Policy holder _____ Policy holder ID# _____ Group ID# _____

Policy holder Date of Birth (MM/DD/YYYY) _____ Policy holder's Relationship to Patient _____

4 HEALTHCARE PROVIDER INFORMATION

Healthcare Provider Name _____ Email _____

Facility Name _____

Street Address _____ City _____ State _____ Zip _____

Phone # _____ Ext # _____ Secure Fax # _____

Office Contact Name _____ Office Contact Phone # _____

Please scan the QR code on page 3 to see Important Safety Information, including BOXED WARNING, or visit XEOMIN.com for Full Prescribing Information.

Patient First Name | Last Name | Date of Birth (MM/DD/YYYY)

Please review this section and SIGN below.

5 PATIENT ATTESTATION

By signing this form, I (as applicable, Patient or Patient's Legal Guardian [Guardian] if patient is a minor) understand that The Lash Group, LLC (Administrator) is administering the XEOMIN Patient Savings Program (Program) on behalf of Merz Pharmaceuticals, LLC (Merz). Administrator will review patient Application form and determine my/patient's eligibility for the Program based on the information provided. Administrator may, at any time require additional information to determine or confirm my/patient's eligibility/ Administrator will notify me if I am/patient is eligible and may provide me with additional information.

HIPAA Authorization to Use and Disclose Information

By signing below and submitting this Application, I understand and authorize my/the patient's health care provider and health insurer to release my/the patient's protected health information, including information contained in this Application or my/the patient's medical records or benefits information, to Administrator and to Merz (Administrator/Merz) and authorize Administrator/Merz to contact me in connection with this Program. Further, I authorize Administrator/Merz to contact my/the patient's insurer and physician to confirm coverage for XEOMIN and eligibility for this Program. I authorize Administrator/Merz to use my/ the patient's information to administer the Program and to communicate with me, my/patient's physician, and my/ patient's insurer. I further authorize Merz or parties acting on its behalf to use my protected health information for marketing activities or to contact me/the patient in the future for market research, clinical trials, and other information it believes to be of interest to me/the patient. I understand that participation in the Program is voluntary and my/patient's health care provider or insurer may not require me to sign this authorization as a condition of treatment or coverage; however, if I do not sign this authorization, I/the patient will be unable to participate in the Program. This authorization will be valid for one (1) year or until my/the patient's participation in the Program ends through my/the patient's cancellation, unless a shorter time is required by applicable law. I also understand and agree: (i) I can obtain a copy of this signed authorization; (ii) I/the patient may revoke this authorization in writing at any time by email to Merz@lashgroup.com, but I/patient will no longer be permitted to participate in the Program after the date the authorization is revoked and my revocation will not impact uses or disclosures of information already made in reliance on this authorization; and (iii) once my/the patient's protected health information has been disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.

Eligibility, Terms and Conditions, and Program Limitations

The Program cover patients' actual out-of-pocket XEOMIN medication costs and, where permissible, related administration fees, up to a maximum amount of $5,000 annually. The Program does not cover (a) office co-pays not directly associated with XEOMIN treatment; (b) facility co-pays not directly associated with XEOMIN treatment, or (c) any other costs excluded by the Program guidelines not specifically mentioned here, which are subject to change.

Eligible patients must be clinically appropriate patients for therapeutic treatment with XEOMIN. Patient must be prescribed XEOMIN. Eligible patient must be at least 2 years of age or younger than 65 years of age.

This offer is valid only in the United States, excluding where its otherwise prohibited by law. Patients residing in the states of Massachusetts and Rhode Island are eligible for drug co-payment assistance only and are not eligible for other types of co-payment assistance, including but not limited to costs related to administration of the drug.

Eligible patients must have private commercial insurance that covers medication cost for XEOMIN, and acceptance of this offer must be consistent with the terms of that insurer's drug benefit. Eligible patients must not have coverage for XEOMIN through Medicare, Medicare Advantage, Medicare Part D, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), the Department of Defense (DoD), or other federally funded or state-funded healthcare programs. Patient who move from commercial to federally funded or state-funded insurance invoice, which must be submitted within 180 days after each treatment.

Patient/Guardian may not and agrees not to seek reimbursement for value received from the Program from any third-party payers, including flexible spending accounts or healthcare savings accounts. If at any time patient begins receiving coverage under any federal-, state-, or government-funded healthcare program, Patient is no longer eligible to participate in the Program and must call 1-844-469-6379, option 4 between 8am – 7pm ET to stop participation. Restrictions may apply. **This is not health insurance.**

Patient/Guardian and pharmacist are responsible for notifying insurance carriers or any other third party who pays for or reimburses any part of the prescription filled using the Program as may be required by the insurance carrier's terms and conditions and applicable law.

Enrollment in the Program will be reviewed on an annual basis to determine continued eligibility. This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer for XEOMIN.

This is a limited time offer, and Merz reserves the right to rescind, revoke, amend, or terminate this offer, or the program in its entirety, at any time without notice.

REQUIRED Signature below certifies that Patient/Guardian have received, understand, accept, and will comply with all eligibility requirements, terms, and conditions of the XEOMIN Patient Savings Program as stated above, and that Patient/Guardian consent to share patient's personal health information included in this Application with the Administrator and Merz as stated above.

Patient/Legal Guardian Name *(Please print)* | Patient/Legal Guardian Signature | Date

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Patient First Name | Last Name | Date of Birth (MM/DD/YYYY)

6 PROGRAM SAVINGS

If you would like to receive eligible Program benefits directly to your street address provided above, *please sign section A*.

A.

Patient/Legal Guardian Name *(Please print)* | Patient/Legal Guardian Signature | Date

If you would prefer to assign/send your Program benefits to your Healthcare Provider for your convenience, then *please sign section B. (OPTIONAL)*

B. Sign here if you wish to assign your Eligible Program Savings to your Healthcare Provider

Under the Program rules Program savings are sent directly to you at your address above. If, for your convenience, you would prefer to assign your Program savings directly to the Healthcare Provider listed above so that he or she will use them to pay for eligible costs you would have paid your Healthcare Provider for your XEOMIN treatment, please sign and date below. The Program will then send your program saving directly to your Healthcare Provider directly on your behalf. Please note that you are NOT obligated to assign your Program savings to your Healthcare Provider to participate in the Program. Also, if you later decide that you no longer wish to assign your Program savings for future payments to your Healthcare Provider, you can submit a new enrollment form so that you receive future Program savings directly.

I hereby authorize and direct the XEOMIN Patient Savings Program, sponsored by Merz Pharmaceuticals, LLC, to issue payment directly to the Healthcare Provider listed on this form to be used for my eligible XEOMIN-related expenses.

Patient/Legal Guardian Name *(Please print)* | Patient/Legal Guardian Signature | Date

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MERZ THERAPEUTICS