XEOMIN Patient Savings Program Application

Contact the XEOMIN Patient Savings Program by calling **1-844-4MYMERZ (1-844-469-6379)** Monday through Friday between 8am-8pm ET

Please fax application to 1-888-481-0547

PLEASE VERIFY TYPE OF ENROLLMENT:

○ New Enrollment ○ Update to Existing Enrollment ○ Re-Enrollment

SECTION 1: PATIENT INFORMATION

(Please attach an enlarged copy of the front and back of the applicant's insurance card and/or other insurance information along with this form)

First Name: Last Name: MI:

Address:

City: State: Zip:

Legal Guardian Name: Relationship to Patient:

Patient DOB (mm/dd/yyyy): Gender: ○ Male ○ Female

Patient Phone: Legal Guardian Phone:

Patient/Legal Guardian Email (name@domain.com):

Primary Insurance Name:

Primary Insurance Phone: Group#: ID#:

Secondary Insurance Name: Secondary Insurance Phone:

Prescription Insurance Name: Prescription Insurance Phone:

BIN: PCN: Group#: ID#:

○ Yes ○ No Has patient received botulinum neurotoxin therapy in the past?

○ Yes ○ No Is this the patient's first XEOMIN treatment?

○ Yes ○ No Does patient have healthcare insurance?

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

○ Yes ○ No Is patient currently a resident of the United States or Puerto Rico?

○ Yes ○ No Does patient live in: Massachusetts, Michigan, Rhode Island, or Minnesota?

○ Yes ○ No Is 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?

Patient must have commercial insurance that pays for XEOMIN to receive assistance through this program. If patient or physician would like assistance determining insurance coverage and out-of-pocket costs for XEOMIN before you receive the product, please call 1-844-4MYMERZ (1-844-469-6379). The information in this section is to evaluate eligibility for the XEOMIN Patient Savings Program, which is designed to assist patients with out-of-pocket costs related to XEOMIN treatment. If patient/legal guardian have any questions regarding the enrollment decision or the XEOMIN Patient Savings Program, please contact us at 1-844-4MYMERZ (1-844-469-6379) between 8am-8pm ET.

SECTION 2: PATIENT'S HEALTHCARE PROVIDER INFORMATION

Physician Name: Practice Name:

Practice Contact Name: Practice Phone:

Practice Address: Practice Fax:

City: State: Zip:

IMPORTANT CONSUMER SAFETY INFORMATION

XEOMIN (Zeo-min) may cause serious side effects that can be life threatening. See additional Important Consumer Safety Information in the Patient Savings Program brochure that was provided with this application. Read the Medication Guide before you start receiving XEOMIN and each time XEOMIN is given to you as there may be new information. For Full Prescribing Information and Medication Guide, visit XEOMIN.com.

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SECTION 3: SIGNATURES

To process the Application and authorize enrollment, patient must sign this Application form.

Enrollment

By signing this form, I (as applicable, Patient or Patient's Legal Guardian ("Guardian") if patient is a minor) understand that TrialCard Incorporated (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.

Authorization to Use and Disclose Information

By signing below and submitting this Application, I understand and authorize the release of my/the patient's personal health information contained in this Application to Administrator and to Merz (Administrator/Merz) and authorize Administrator/Merz to contact me in connection with this Program and as described below. Further, I authorize Administrator/Merz to contact patient insurer and patient physician to confirm coverage for XEOMIN and eligibility for this Program. I authorize Administrator/Merz to use patient information to administer the Program and to communicate with me, my patient's physician, and my patient's insurer. I may revoke this authorization at any time, but I understand that patient will no longer be permitted to participate in the Program after the date the authorization is revoked.

I, as the patient/Guardian, understand that the information given will remain confidential, as will any information provided by me or others. Merz or parties acting on its behalf may contact patient in the future for market research, clinical trials, and other information it believes to be of interest to me/the patient. I/Patient may request that name, and other information be removed from future contacts by calling 1-888-4MYMERZ (1-888-469-6379) between 8am-8pm ET. The Program does not sell personal information to third-party companies.

Eligibility, Terms and Conditions, and Program Limitations

The Program covers 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 patients must be at least 2 years of age and younger than 65 years of age.

This offer is valid only in the United States, excluding where it is otherwise prohibited by law. Patients residing in the states of Massachusetts, Michigan, Rhode Island, and Minnesota 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 costs 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. Patients who move from commercial to federally funded or state-funded insurance will no longer be eligible for the Program. Proof required for receiving payment for out-of-pocket drug costs must be a valid Explanation o fBenefits (EOB) or specialty pharmacy invoice, which must be submitted within 120 days after each treatment.

Patient/Guardian may not 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 1-844-4MYMERZ (1-844-469-6379) between 8am-8pm 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 o rreimburses 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.

Signature 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:**