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PROGRAM APPLICATION

PATIENT INFORMATION

Patient Name	Date of Birth	
Patient Address		
City	State	Zip
Patient Phone #	Patient Email	
Do you have any government insurance coverage for prescriptions, including without limitation Medicare, Medicaid, the Department of Veterans Affairs healthcare program, TRICARE, and any Federal or state employee benefit program?		Yes ☐ No ☐
Are you a resident of the fifty U.S. States, the District of Columbia, Puerto Rico, or the U.S. Virgin Islands?		Yes ☐ No ☐

AUTHORIZATION FOR PROGRAM PARTICIPATION AND DISCLOSURE OF PATIENT INFORMATION. I understand that the Program offering is contingent upon my ability to meet the eligibility criteria for the HEARTFELT CO-PAY ASSISTANCE PROGRAM ("Program") as determined by Ferring Pharmaceuticals Inc.. ("Ferring") or third parties contracted by Ferring. I agree that Ferring does not have any obligation of any offering under this Program to me and I waive any and all liability of Ferring under this Program. I understand that by completing this form, I am not guaranteed eligibility to receive co-pay assistance for the Covered Medication. In the event I am eligible for the Program, I acknowledge that this Program expires on December 31, 2023. I also understand that the Program may be changed or discontinued at any time without any notice to me and at such time the Program offerings will no longer be provided. I certify that I am not enrolled in any Federal or state health care program, including without limitation Medicare, Medicaid, the Department of Veterans Affairs healthcare program, TRICARE, and any Federal or state employee benefit program. I agree that I will report any assistance I may receive through the Program to my insurance company as may be required by my benefit agreement. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the Program if my insurance status changes.

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me to disclose any information regarding my health, treatment, and coverage that pertains to his application for the Program to Ferring Pharmaceuticals Inc. its affiliates, or contracted third parties for the following purposes: (i) to determine eligibility for the Program, (ii) to administer, evaluate, and maintain the high quality of the Program; and (iii) for Ferring's internal business purposes, including quality control and research. I understand that once the Program receives my health information, it may communicate with my health care providers and insurers to determine Program eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program (should I qualify). I understand that I may cancel this authorization at any time by writing to the Program as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in the Program. Once the Program receives and processes my cancellation request, the Program will not use my health information going forward. I understand that cancelling the Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 3 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the Program and will no longer be protected by HIPAA.

Patient Authorization: Date:

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PROGRAM APPLICATION

PRESCRIBER INFORMATION

Prescriber's Name	Office Name	
Prescriber's Address		
City	State	Zip
Office Phone #	Office Fax #	
Office Contact Name		
State License #	State where licensed:	NPI#:

REPLACEMENT MEDICATIONS

MENOPUR

☐ MENOPUR (menotropins for injection)

Directions:

Quantity:

FYREMADEL

☐ FYREMADEL (ganirelix acetate) injection

Injections:

Quantity:

Replacement Medications are the quantity of MENOPUR and FYREMADEL (ganirelix acetate) injection used prior to patient's cycle cancellation.

I certify that the information provided in this application is complete and accurate to the best of my knowledge, I certify that the above-named patient initiated a COS cycle with the Covered Medications and had that COS cycle canceled due to: a) a COVID-19 diagnosis or COVID-19 treatment facility closure occurring between March 1, 2020 through December 31, 2023 and who is initiating a new COS cycle between June 15, 2020 through December 31, 2023; or b) a natural disaster resulting in a federal or state of emergency occurring between February 1, 2021 through December 31, 2023 and who is initiating a new COS cycle between March 1, 2021 through December 31, 2023. I certify that the prescription information provided is for a new COS cycle. I understand eligibility under this program is subject to the Program's approval and the patient's continuing compliance will all eligibility requirements, as set by Ferring. I agree to allow Ferring or its authorized agent(s) to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the Program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient to Ferring and authorized third parties designated by Ferring.

Prescriber Signature:	Date:

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CO-PAY ASSISTANCE PROGRAM

The COVID Cycle Cancellation/Restart Program (the "Program") provides co-pay assistance for eligible commercially insured patients whose controlled ovarian stimulation ("COS") cycle was canceled due to: a) a COVID-19 diagnosis or COVID-19 treatment facility closure occurring between March 1, 2020 through December 31, 2023 and who is initiating a new COS cycle between June 15, 2020 through December 31, 2023; or b) a natural disaster resulting in a federal or state of emergency occurring between February 1, 2021 through December 31, 2023 and who is initiating a new COS cycle between March 1, 2021 through December 31, 2023. The Program offers up to a maximum of a $250.00 rebate towards co-pay costs paid for MENOPUR and Ferring's FYREMADEL (ganirelix acetate) injection prescribed as part of a COS cycle (the "Covered Medications"). Please see Program Terms and Conditions below.

Eligible patients are U.S. residents have commercial insurance and who satisfy the terms and conditions below:

Terms and Conditions:

- Patient must be 18 years of age or older.
- Patient must be a resident of the United States or U.S. Territories.
- Patient must have had an initial COS cycle with the Covered Medications and had her COS cycle canceled due: a) COVID-19 diagnosis or COVID-19 treatment facility closure occurring between March 1, 2020 through December 31, 2023 and who is initiating a new COS cycle between June 15, 2020 through December 31, 2023; or b) a natural disaster resulting in a federal or state of emergency occurring between February 1, 2021 through December 31, 2023 and who is initiating a new COS cycle between March 1, 2021 through December 31, 2023.
- Patients must provide medical records for proof of cycle cancellation and medications utilized prior to COS cancellation.
- Patient must have an Rx for a new COS cycle.
- Patient must have been commercially insured at the time of her cycle cancellation.
- Patients participating in any Federal or state health care program, including without limitation Medicare, Medicaid, the Department of Veterans Affairs healthcare program, TRICARE, and any Federal or state employee benefit program are not eligible for the Program.
- Patient must notify the Program if their insurance status changes.
- Patient is responsible for reporting participation in the Program to their insurer to the extent required by their insurer.
- All required forms must be completed accurately and submitted with supporting documentation to determine program eligibility.
- Patient must provide supporting documentation showing the itemized out-of-pocket costs for the Covered Medications for the cancelled cycle.
- Void if prohibited by law, or restricted. The selling, purchasing, trading, or counterfeiting of this offer is prohibited by law.
- This Program is not health insurance.
- Offer may not be combined with any other discount, coupon, or other offer.
- No other purchase necessary.
- Offer expires December 31, 2023.
- Ferring Pharmaceuticals reserves the right to rescind, revoke, or amend this offer at any time without notice.
- When you use this offer, you are certifying that you understand the program rules, regulations, and terms and conditions, and that you will comply with them.

Checklist for submitting an application:

- Ensure all sections of the application are completed. Please make a copy before sending as no documents will be returned;
- Patient's signature and date are required on the application;
- Medical records for proof of utilization of covered medications of cancelled cycle;
- Prescriber's signature and date are required on the application. Stamps are NOT acceptable;
- Rx for new COS cycle;
- Supporting documentation reflecting co-pay costs for MENOPUR and FYREMADEL (ganirelix acetate) injection of cancelled cycle (i.e. itemized pharmacy receipt, or Explanation of Benefits from your insurance provider);
- Email the completed application and documentation to HeartFelt@envisionrx.com;

Upon receipt of a completed application, the patient will be notified of program eligibility. If the patient is eligible for the Program, a check in the off-set amount will be mailed to the patient within (45 days) of eligibility notification.

Please contact HeartFelt@envisionrx.com with any questions or for additional assistance.
We can be reached at this email Monday-Friday 9am-5pm EST.

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