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 any assistance in the form of medication replacement is contingent upon my ability to meet the eligibility criteria for the HEARTFELT DRUG REPLACEMENT PROGRAM ("Program") as determined by Ferring Pharmaceuticals Inc. ("Ferring") or third parties contracted by Ferring. I agree that Ferring does not have any obligation to provide me with medication replacement and I waive any and all liability of Ferring in the provision of the offerings under this Program. I understand that by completing this form, I am not guaranteed eligibility to receive medication at no cost under the Program. In the event I am eligible for the Program, I acknowledge that 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 services will no longer be provided. I certify that I paid cash for my Covered Medications for my canceled cycle due to COVID-19 or a natural disaster and 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 not seek reimbursement for MENOPUR or FYREMADEL (ganirelix acetate) injection from any government program, health plan, or other third-party insurer, nor will I seek to have this prescription, or any cost associated with it counted as part of my deductible or out-of-pocket cost for prescription drugs. 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. If I am eligible for participation in the Program I authorize Ferring to forward this prescription to a dispensing pharmacy on my behalf.

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 payment for medication to 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 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. 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#:

Please check one of these check boxes

- ☐ COS cycle cancellation due to COVID-19
- ☐ COS cycle cancellation due to natural disaster

REPLACEMENT MEDICATIONS

MENOPUR	FYREMADEL
☐ MENOPUR (menotropins for injection) Quantity:	☐ FYREMADEL (ganirelix acetate) injection Quantity:

Replacement medications are the quantities of MENOPUR and FYREMADEL (ganirelix acetate) injection that were 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, that the product ordered hereunder is medically necessary for this patient, and that I will be supervising the patient's treatment. I certify that the above-named patient had a COS cycle cancellation due to: a) COVID-19 between March 1, 2020 and December 31, 2023; or b) a natural disaster resulting in a federal or state emergency between February 1, 2021 and December 31, 2023. I certify that the prescription information set forth above 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 with 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 and the patient's receipt of any product(s) provided to him or her through the Program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient to Ferring, and contractors designated by Ferring. I authorize Ferring, its affiliated companies, or its subcontractors to forward the accompanying prescription to a dispensing pharmacy on behalf of myself and my patient.

Prescriber Signature:	Date:

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MEDICATION REPLACEMENT PROGRAM

The HEARTFELT Medication Replacement Program (the "Program") provides medication replacement for eligible cash-paying patients whose controlled ovarian stimulation ("COS") cycle was canceled as a result of: 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. Please see Program Terms and Conditions below.

The Program offers medication replacement for MENOPUR (up to 15 vials) and Ferring FYREMADEL (ganirelix acetate) injection (up to 5 syringes) (the "Covered Medications") upon new COS cycle initiation for eligible patients who paid cash for their Covered Medications for their canceled cycle . Quantities will be determined based on the amount of Covered Medications used in the canceled cycle.

Eligible patients are U.S. residents who have no insurance coverage or who only 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 a COS cycle cancellation 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;
- Patient must have used MENOPUR as part of canceled cycle;
- Patients must provide medical records for proof of medications utilized prior to COS cancellation;
- Patient must submit a Rx for a new COS cycle;
- Patient must have paid cash for their medications for their canceled COS cycle;
- 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 must not seek reimbursement from their insurance plan for their out-of-pocket costs for Covered Medications;
- All required forms must be completed accurately and submitted with supporting documentation to determine program eligibility;
- Patient must provide documentation showing proof of purchase for Covered Medications from the patient's canceled COS cycle (i.e. itemized pharmacy receipt);
- 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;
- Prescriber's signature and date are required on the application. Stamps are NOT acceptable;
- Medical records for utilization of medications prior to COS cancellation;
- Rx for new COS cycle;
- Supporting documentation showing proof of purchase of Covered Medications (i.e., itemized pharmacy receipt);
- Fax or email the completed application and documentation to 833-682-1184, HeartFelt@envisionrx.com, ATTN: HEARTFELT;

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If the patient is eligible for the Program, the replacement medication will be shipped to the patient by the Program specialty pharmacy vendor, Envision Specialty Pharmacy and the Rx will then be transferred to pharmacy identified by prescriber/patient to dispense non-replacement medications.

Please contact the Program at 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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