THE AMNEAL PATIENT ASSISTANCE PROGRAM

We make healthy possible®

The Amneal Patient Assistance Program offers eligible individuals the opportunity to apply to receive free medication for up to one year of: EMVERM® (mebendazole) chewable tablets and RYTARY® (carbidopa and levodopa) extended-release capsules, as listed on page 2 of this document.

Also on page 2 you'll find eligibility requirements, instructions and contact information.

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PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

Thank you for your interest in the Amneal Patient Assistance Program. This program is for RYTARY® (carbidopa and levodopa) extended-release capsules and EMVERM® (mebendazole) chewable tablets, as listed below. Attached is a copy of the application form.

To be eligible to receive free medicine from Amneal, patients must be residents of US, Puerto Rico or US Virgin Islands, not have affordable coverage for the prescription, have total household income that meets the program eligibility requirements and, if enrolled in a Medicare Part D plan, have spent at least 3% of annual household income out-of-pocket on prescription medicines.

APPLICATION INSTRUCTIONS FOR PATIENTS - REQUIRED

- Complete all 3 of the following sections:
  - Patient Information (Section 1)
  - Insurance Information (Section 2)
  - Income Information (Section 3)
- Sign the application
- **If you have a Medicare Part D plan,** attach proof of what your household has spent on prescription drugs this year. You will need to provide one of the following: Explanation of Benefits Statement from your Medicare Part D plan provider or a pharmacy printout of year-to-date prescription history.

APPLICATION INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

- Complete Practitioner Information Section 4. Provide phone, fax, and DEA or State License number.
- Have patient complete the Patient Information Sections 1, 2, and 3 and sign the application.
- Attach original valid prescription(s) with physician signature.
- Fax or mail the application, financial documentation, proof of prescription spend (if applicable) and prescription to:

Amneal Patient Assistance Program
PO Box 220586
Charlotte, NC 28222

Phone 1-877-764-9021 Fax 1-877-764-9022

If approved, patients are eligible to receive free medication for up to one year. Medications will be shipped to the patient's home. The Amneal Patient Assistance Program will send an application for renewal when a patient's enrollment is due to expire.

Please call 1-877-764-9021 for questions regarding this program or application.
Monday through Friday, 8:00 am to 5:00 pm CST

THE FOLLOWING MEDICATIONS ARE AVAILABLE THROUGH THE AMNEAL PATIENT ASSISTANCE PROGRAM

*If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form.

RYTARY® in the following strengths
(available in a 30, 60 or 90 day supply)
RYTARY® 23.75 mg / 95 mg
RYTARY® 36.25 mg / 145 mg
RYTARY® 48.75 mg / 195 mg
RYTARY® 61.25 mg / 245 mg

EMVERM®100mg Chewable Tablets-1 count package.
(Providers please include a separate prescription for every member of the applicant's household being treated with Emverm®)

SECTION 1 - PATIENT INFORMATION: (PLEASE PRINT CLEARLY)

NOTE: UPON APPROVAL, MEDICATION WILL BE SHIPPED TO THE PATIENT'S ADDRESS

Last Name, First Name:	Social Security or ID Number: / /	Patient Date of Birth:
Street Address/Shipping Address:	Phone Number: ( )	U.S. Resident: ☐ Yes ☐ No
	Diagnosis ICD-10*	
City: State: Zip Code:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower	Gender: ☐ Male ☐ Female
List any other Patient Medications:	U.S. Veteran: ☐ Yes ☐ No	Disabled: (Approved by Social Security) ☐ Yes ☐ No
List any Patient Drug Allergies:	Number of people in household (include self): (circle one) 1 2 3 4 5 6 7	

For additional household members receiving treatment with Emverm®:

1ST MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

2ND MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

3RD MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

4TH MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

5TH MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

6TH MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

7TH MEMBER:

First Name **Last Name:** **DOB:** **Drug Allergies:**

Prescription included: ☐ Yes ☐ No Diagnosis ICD-10*

SECTION 2 - PATIENT INSURANCE INFORMATION

Do you have a State Patient Assistance Program?	☐ Yes ☐ No
Do you have Medicaid?	☐ Yes ☐ No
Do you have Medicare A	☐ Yes ☐ No
Do you have Medicare B?	☐ Yes ☐ No
Do you have Medicare D? *(If yes, Please attach current years proof of Out-of-Pocket Prescription costs)*	☐ Yes ☐ No
Do you have prescription drug coverage? *(If yes, please attach a copy of your insurance card front and back.)*	☐ Yes ☐ No

*DIAGNOSIS ICD-10 CODES

B71.9 Intestinal infection caused by cestodes
B76.0 Ancylostomiasis
B 76.1 Infection due to Necator americanus
B77 Ascariasis
B77.9 Ascariasis, unspecified
B79 Trichuriasis
B80 Enterobiasis
B82.0 Intestinal helminthiasis, unspecified
G20 Parkinson's disease
G21.2 Secondary Parkinson's due to other external agents
G21.3 Postencephalitic parkinsonism

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SECTION 3 - PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing below, I authorize my healthcare provider(s) and health insurer(s) to disclose personal health information about me related to my treatment or potential treatment with RYTARY or EMVERM medication ("My Information") Amneal Pharmaceuticals LLC's patient assistance program service providers and authorized agents (collectively, the "Assistance Group") for purposes of my enrollment and participation in the Amneal Patient Assistance Program (the "Program"). In turn, I authorize the Assistance Group to use and to disclose My Information to my healthcare provider(s) and health insurer(s), and to the Centers for Medicare and Medicaid Services ("CMS"), as deemed necessary to verify the accuracy and completeness of this Program application, and to administer and provide services available through the Program. I understand that when My Information is disclosed to the Assistance Group, it may be subject to re-disclosure and no longer protected by federal privacy, law, but that the Assistance Group intends to use and disclose My Information only as described in this Authorization.

I understand that I may decline to sign this form and that will not affect the way my health care providers or insurer(s) will provide me with their respective services, although I will then be ineligible to participate in the Program. I also understand that I may cancel this Authorization at any time by sending a notice of cancellation to the Assistance Group at: Amneal Patient Assistance Program, PO BOX 66554 St. Louis, MO 63166-6554 (and that any such cancellation will not apply to uses and disclosures made in reliance on the Authorization prior to the Assistance Group's receipt of the notice of cancellation). If I do not cancel the Authorization, it will remain valid for the duration of the period I am enrolled in the Program, or such lesser period as may be required by applicable state law.

I am entitled to receive a copy of this Authorization once it is signed below.

Name of Patient	Signature	Date
Name of Legal Representative	Signature	Date

If signed by representative, state relationship to patient: _____

PATIENT INFORMED CONSENT TO TERMS AND CONDITIONS OF PATIENT ASSISTANCE PROGRAM

I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Amneal Patient Assistance Program ("Program") if I obtain coverage through another source or if I no longer meet the income criteria for the Program.

I authorize the Program and its administrators to obtain a consumer report on me. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from the program. Upon request, the Program will provide me the name and address of the consumer reporting agency that provides the consumer report.

I understand that completing this form does not ensure that I will qualify for the Program. I understand that Amneal Pharmaceuticals LLC reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program.

Name of Patient _____ Signature _____ Date _____

Name of legal representative _____ Signature _____ Date _____

SECTION 4 - PRACTITIONER INFORMATION: (PLEASE PRINT CLEARLY)

Last Name, First Name _____ Office Contact Person _____

Office Street Address _____ City _____ State _____ Zip Code _____

Phone Number ( ) _____ Fax Number ( ) _____

State License # (or DEA#, if required) _____

SECTION 5 - PRESCRIPTION INFORMATION AND ATTESTATION

*Prescriber signature must be the same as the prescriber name above.

Patient Name: _____

Patient Date of Birth: _____

Medication and Strength: _____

Directions: _____

Quantity: _____ Refills: _____

Current Medications: _____

Known Allergies: _____

By signing below, I verify that the information provided in this enrollment form is complete and accurate to the best of my knowledge. I understand that Amneal Pharmaceuticals LLC reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through Amneal Patient Assistance Program. Finally, I authorize Amneal Pharmaceuticals LLC, its affiliates, representatives and agents to forward the above prescription, by fax or other mode of delivery, to a pharmacy for fulfillment.

Prescriber Signature _____ Dispense as Written _____ Date of Signature _____

Provider State License # _____ Substitution Permitted? _____

*NY state prescribers must submit prescription on original NY state serialized prescription blank, via E-script or verbally to the pharmacy pursuant to NY state laws.