

Enrollment Application Form

Please complete the information listed below to apply for Solstice Neurosciences, LLC ("Solstice") Co-Pay Assistance Program. If you need assistance completing the application, please call **888-461-2255, Option 3. Completing this application does not guarantee acceptance into the Solstice Co-Pay Assistance Program.**

Patient Information

Patient ID:

Patient Information	Patient Legal Last Name:	Legal First Name:	Middle:	Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/>
	E-mail Address:	Primary Phone: H <input type="checkbox"/> C <input type="checkbox"/> Other <input type="checkbox"/> ()		Secondary Phone: H <input type="checkbox"/> C <input type="checkbox"/> Other <input type="checkbox"/> ()
	Mailing Address:			P.O. Box: <input type="checkbox"/> N/A
	City:	State:	Zip Code:	MYOBLOC® Dosage (# of vials; vial size):
	Social Security Number: (- -)	Date of Birth (MM/DD/YYYY): / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pharmacy or Site of Care: <input type="checkbox"/> Unknown

Alternate Contact Information

Alternate	Alternate Contact Last Name:	First Name:	Middle:
	Relationship to Patient:	Primary Phone: H <input type="checkbox"/> W <input type="checkbox"/> Other <input type="checkbox"/> ()	Secondary Phone: H <input type="checkbox"/> W <input type="checkbox"/> Other <input type="checkbox"/> ()

Financial Information

Financial	Total Annual Household Income:	Household Size:	Current Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled
	Has your annual income changed significantly in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, how much: Up \$ _____ Down \$ _____		

Annual Household Income – Money earned by all persons associated with an U.S. Individual Income Tax Return.

Household Size – Number of persons associated with the Annual Household Income and/or who are claimed on an U.S. Individual Income Tax Return.

Insurance Information

Insurance Information	Type of Primary Insurance Coverage, check the box below that applies (<i>Include copies of insurance cards medical and, if applicable, pharmacy benefit</i>): <input type="checkbox"/> No Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Medical Aid <input type="checkbox"/> Commercial Coverage <input type="checkbox"/> Other _____			
	Name of Primary Insurance:		Cardholder First and Last Name:	Relationship to Applicant:
	Member ID #:	Group #:	Primary Phone: ()	Secondary Phone: ()
	Type of Secondary Insurance Coverage, check the box below that applies (<i>Include copies of insurance cards medical and, if applicable, pharmacy benefit</i>): <input type="checkbox"/> No Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Medical Aid <input type="checkbox"/> Commercial Coverage <input type="checkbox"/> Other _____			
	Name of Secondary Insurance: <input type="checkbox"/> N/A		Cardholder First and Last Name:	Relationship to Applicant:
	Member ID #:	Group #:	Primary Phone: ()	Secondary Phone: ()

Required Documentation

Specific supporting documentation must be submitted along with this application in order to receive assistance from the Solstice Co-Pay Assistance Program. Please read the following information carefully and return the appropriate paperwork with the completed application.

Insurance Information Documentation

- Copies of both front and back of medical insurance card(s). In some circumstances, MYOBLOC® (rimabotulinumtoxinB) Injection may have coverage under a prescription drug benefit; in that case, provide the prescription drug benefit card(s), both front and back
- Completed Benefit Investigation by the MYOBLOC Reimbursement Support Program team

Please see Important Safety Information below and visit www.myobloc-reimbursement.com for the full Prescribing Information and Medication Guide for MYOBLOC.

Please note: Documentation verifying your **TOTAL ANNUAL HOUSEHOLD INCOME** is required to obtain assistance. You must provide **one or any combination of the following documents** (or their equivalents) in order to report the total annual household income:

Financial Information Supporting Documentation

- Copy of most recent federal tax return
- Most recent W-2 or 1099 for each member of the household
- Statement showing retirement/pension benefits of any type, if applicable
- Copy of most recent pay stub or letter from employer clearly stating compensation

Mail or Fax the completed and signed application with supporting documents to:

- **Address: 4700 Millenia Blvd., Suite 500, Orlando, FL 32839**
- **Fax: (877) 335-4412**

MYOBLOC is indicated for the treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

IMPORTANT SAFETY INFORMATION

MYOBLOC has a boxed warning related to the distant spread of toxin effect: The effects of MYOBLOC and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms. In unapproved uses, including spasticity in children and adults, and in approved indications, cases of spread of effect have occurred at doses comparable to those used to treat cervical dystonia and at lower doses.

The most frequently reported adverse events with MYOBLOC are dry mouth, dysphagia, dyspepsia, and injection site pain. The vast majority of these adverse events were mild to moderate, temporary, self-resolving, and more common with higher doses. These adverse events may occur within the first week following treatment and may have a duration of several months. In controlled clinical trials, few patients (<1%) stopped treatment due to dry mouth or dysphagia. There is a reduced frequency of dry mouth and dysphagia reported with continued treatment. Dysphagia has commonly been reported by patients treated with all botulinum toxins for cervical dystonia.

Caution should be exercised when administering MYOBLOC to individuals with motor neuron disease (eg, amyotrophic lateral sclerosis), peripheral motor neuropathic diseases (eg, motor neuropathy) or neuromuscular junctional disorders (eg, myasthenia gravis or Lambert-Eaton syndrome). These patients may be at increased risk of clinically significant systemic effects including severe dysphagia and respiratory compromise from typical doses of MYOBLOC. In these patients, rare cases of dysphagia severe enough to cause aspiration pneumonia or to warrant the insertion of a gastric feeding tube have also been reported.

Coadministration of MYOBLOC and aminoglycosides or other agents interfering with neuromuscular transmission (eg, curare-like compounds) should only be performed with caution as the effect of the toxin may be potentiated.

Agreements

Compliance: I understand that if I am accepted into the Solstice Neurosciences, LLC (“Solstice”) Co-Pay Assistance Program, financial assistance is being provided to help me afford my MYOBLOC medication, prescribed by my physician for its U.S. FDA-approved indications. Therefore, my medication must be administered in accordance with my doctor’s directions. I understand I may be removed from the Solstice Co-Pay Assistance Program if I am not compliant with the regimen my doctor prescribed and for which I am receiving this financial assistance. Likewise, in the event I no longer need financial assistance because this medication is no longer being administered, or I have found other means of assistance, I may be removed from the Solstice Co-Pay Assistance Program.

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand I am free at any time to switch healthcare providers, practitioners, pharmacies, commercial insurers, or suppliers without affecting my continued eligibility for assistance. I understand my application for assistance does not guarantee funding will be available. I understand if I am awarded financial assistance, it will be provided on an annual basis. I must reapply for assistance each year. Funding in any subsequent year(s) or timeframes is not guaranteed. The Solstice Co-Pay Assistance Program may be modified or discontinued at any time.

Provision of Assistance: I acknowledge that the Solstice Co-Pay Assistance Program has been established to help patients in need of financial assistance with their MYOBLOC medication and who qualify based on the guidelines established by the program. I further agree that if approved for assistance I must maintain my qualification status in order to continue receiving assistance from the Solstice Co-Pay Assistance Program.

I also agree that if at any time during the approved assistance period, my insurance benefit changes, I will immediately inform the Solstice Co-Pay Assistance Program. If I am no longer in need of assistance, or in need of less assistance, my qualification status may change and the Solstice Co-Pay Assistance Program may cease providing me assistance or may reduce the amount of assistance allocated to me for the balance of the year.

I understand I cannot participate in the Solstice Co-Pay Assistance Program if I receive benefits from any Medicare, Medicaid, or Veterans benefit programs or if I am a resident of the Commonwealth of Massachusetts. Furthermore, at any time during the approved assistance period, if I begin receiving benefits from a government program, then I am no longer eligible for participation in this program. Likewise, if I begin receiving government benefits and any portion of the benefits are for retroactive, prescription drug financial assistance, I will be responsible for reimbursing the Solstice Co-Pay Assistance Program for the same amount of retroactive funding that I received for the medication assistance I received under this program.

Limitation of Liability: I agree that the Solstice Co-Pay Assistance Program, the program administrators (The Assistance Fund, Inc. and Health Connections), its employees, officers, and board members; sponsors, sponsors’ employees, officers and board members; and donors, donors’ employees, officers and board members shall not be liable for any damages of any kind, without limitation, arising out of or in connection with receiving co-pay assistance or other benefits or services provided as a part of this program.

Signature of Patient or Patient’s Representative

Date

Print name of Patient’s Representative (if applicable)

Relationship to Patient (if applicable)

Phone: (888) 461-2255, Option 3

Fax: (888) 343-3275

Website: www.myobloc-reimbursement.com

Patient Authorization to use or release Protected Health Information

I authorize the use and disclosure of my individually identifiable health information ("Protected Health Information") by the Solstice Neurosciences, LLC ("Solstice") Co-Pay Assistance Program and the program administrators, The Assistance Fund, Inc., a non-profit organization, and Solstice Neurosciences, LLC reimbursement services administrator, Health Connections (hereafter "The Co-Pay Providers"). The Co-Pay Providers are authorized to process my application for the Solstice Co-Pay Assistance Program, to enroll me in this program if I am eligible and funds are available, and to administer this program if I am enrolled.

I authorize my health care provider and insurance company to disclose my Protected Health Information verbally or in writing to the Solstice Co-Pay Assistance Program and The Co-Pay Providers for use for the purposes stated above. I understand that my Protected Health Information may be subject to re-disclosure pursuant to this authorization. I may withdraw this authorization by mailing or faxing a letter of revocation to the program administrator, The Assistance Fund, Inc., but if I do, it will not have an effect on any actions The Assistance Fund, Inc. took before it received revocation of this authorization. If I revoke this authorization, I will no longer be eligible to receive assistance through this program. This authorization has no expiration date.

I authorize the Solstice Co-Pay Assistance Program and The Co-Pay Providers to use and disclose my Protected Health Information to financially assist me to obtain my medication. I understand I may request copies of the Protected Health Information described in this authorization.

Signature of Patient or Patient's Representative

Date

Print name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

Authorization to Contact Patient

By checking the box below:

- The Solstice Neurosciences Co-Pay Assistance Program may not contact me via text message regarding my assistance.

Phone: (888) 461-2255, Option 3

Fax: (888) 343-3275

Website: www.myobloc-reimbursement.com