oneheart

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 ☐

QUANTITIES PURCHASED OF MEDICATIONS

MENOPUR	NOVAREL	GANIRELIX	ENDOMETRIN
☐ MENOPUR (vials)	☐ NOVAREL (vials)	☐ GANIRELIX (syringes)	☐ ENDOMETRIN (inserts)
Quantity:	Quantity:	Quantity:	Quantity:

AUTHORIZATION FOR PROGRAM PARTICIPATION AND DISCLOSURE OF PATIENT INFORMATION. I understand that the rebate offer provided is contingent on my ability to meet the eligibility criteria for the program as determined by Ferring Pharmaceuticals Inc. ("Ferring") or third parties contracted by Ferring. I understand that by completing this form, I am not guaranteed eligibility to receive the rebate under the program. If I am eligible for the rebate, I acknowledge that the program may be changed or discontinued at any time without notice to me and at such time the rebate will no longer be provided. I certify that I am commercially insured or a cash-pay patient 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 report any assistance I may receive through this 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. Ferring Pharmaceuticals reserves the right to rescind, revoke, or amend this offer without notice. The selling, purchasing, trading, or counterfeiting of this form is prohibited by law. This offer expires on 6/30/2022.

I understand that by signing this form I am giving my permission for the disclosure and use of my protected health information to Ferring Pharmaceuticals Inc., its affiliates and its contracted third parties, to disclose information regarding the use and payment of my medication for the following purposes: (i) to determine eligibility for the program, (ii) administer, evaluate and maintain the quality of the program, and (iii) for Ferring's internal business purposes. I understand that I am not required to sign this form and provide my authorization. However, I understand that if I do not sign this form, I cannot take part in the program and receive a rebate, even if I qualify. I understand that I may cancel this authorization at any time by writing to the program. 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 information going forward. I understand that cancelling the authorization will not affect any use of my 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 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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FERRING PHARMACEUTICALS

oneheart

MEDICATION PROGRAM

Ferring's OneHeart Program (the "Program") offers up to a $200 rebate for out-of-pocket cost incurred by eligible cash-paying or commercially insured patients who undergo a controlled ovarian stimulation ("COS") cycle between June 1, 2020 – June 30, 2022 utilizing Ferring's reproductive medicine portfolio. Minimum purchase requirements apply.

Eligible patients must 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;
- 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 have a COS cycle initiated between June 1, 2020 – June 30, 2022;
- All Program Medications must be purchased by June 30, 2022;
- Patient must have been prescribed the following quantity minimums of each medication listed for her COS cycle: MENOPUR – minimum of 20 vials; Ferring GANIRELIX – minimum of 5 syringes; NOVAREL – minimum 5000IU; ENDOMETRIN – minimum of 2 boxes (42 inserts), collectively ("Program Medications");
- Patient must have paid cash for her Program Medications or is commercially insured;
- All required forms completed accurately and supporting documentation must be submitted within 90 days of last Program Medication purchased;
- Patient must provide documentation showing proof of purchase for required Program Medications for COS cycle (i.e. itemized pharmacy receipt or Explanation of Benefits (EOB));
- 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;
- Commercially insured patients are responsible for reporting participation in the Program to their insurer to the extent required by their insurer;
- Offer may not be combined with any other discount, coupon, or other offer except for the ENDOMETRIN Instant Savings coupon;
- No other purchase necessary;
- Offer expires June 30, 2022;
- Ferring Pharmaceuticals reserves the right to rescind, revoke, or amend this offer at any time without notice; and
- When you use this offer, you are certifying that you understand the program rules, regulations, 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.
- Supporting documentation showing proof of purchase of Program medications (i.e., itemized pharmacy receipt or EOB)
- Email the completed application and documentation to OneHeart@envisionrx.com

Upon receipt of a completed application and supporting documentation, the patient will be notified of program eligibility. If the patient is eligible for the Program, patient will receive a check of up to $200.00 for out-of-pocket costs paid for the Program Medications within 45 days of notification

Please contact the Program at OneHeart@envisionrx.com with any questions or for additional assistance. Someone can be reached Monday-Friday 9am-5pm EST.

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