Amneal PATHways
Patient Access To Health

Patient Support Program Enrollment Form

Program Overview

Amneal PATHways® is a comprehensive program designed to help simplify and support patient access for select Amneal generic and biosimilar products. After enrolling in PATHways, a program Specialist will contact the patient to identify the path through coverage and start them on their way toward treatment. The specialist will discuss the program's services and determine which are best suited to support the patient and their healthcare provider. These services may include:

- Comprehensive coverage and benefit research for the patient's active insurance plans
- Limited support for any prior authorizations required under the patient's insurance policy
- Counseling to share insurance coverage and benefits with the patient
- Information on alternate sources of financial assistance potentially available to the patient
- Sending the patient a product welcome kit (where applicable)

Completing this Form

This multi-page form uses color coding to indicate which sections should be completed by whom. All fields marked with an asterisk (*) are required.

Yellow sections should be completed by the **patient** or their caregiver.
This includes sections 1 through 4 on the subsequent pages. Please note that section 2 provides an option: either fill out the form with information for each insurance carrier, or submit images (scans or photos) of the front and back of each card. Be sure to complete all required and applicable fields, and sign and date section 4 to avoid a delay in enrollment.

Blue sections should be completed by the **Healthcare Provider (HCP)**.
HCPs should complete section 5 through 10. Be sure to include the patient name and date of birth in section 7 and at the top of the last page. All required information must be completed and Section 8 signed and dated in order for us to initiate the program on behalf of the patient.

Acceptable submission methods for this enrollment form include fax, email (scanned or downloaded/edited copy) or through our online HCP portal.

Contact us with any questions about the program or completing the enrollment form.

Contact Us

Call:	Fax:	Visit:
866-4AMNEAL (866-426-6325)	855-690-6573	PATHwaysEnrollmentPortal.com

Call Center Hours: Monday - Friday, 8 AM - 8 PM EST

amneal

*Indicates a required field

1. Patient Information

Name (First, MI, Last)*

Date of Birth (mm/dd/yyyy)* __ __ / __ __ / __ __ __ __

Sex*: ☐ M ☐ F ☐ Other

Street Address*

City* | State* | Zip Code*

Phone* ☐ Home ☐ Mobile ☐ Work

Alt Phone ☐ Home ☐ Mobile ☐ Work

Email Address | Language Preference

Caregiver Contact Information (complete only if applicable)

Caregiver Name | Relationship to Patient

Caregiver Phone ☐ Home ☐ Mobile ☐ Work

Alt Phone ☐ Home ☐ Mobile ☐ Work

Patient Communication Authorizations*:

- ☐ I give permission to PATHways to contact and leave messages for me.
- ☐ I give permission to PATHways to communicate directly with my caregiver on my behalf.
- ☐ I give permission to PATHways to send me helpful SMS messages.
  Message and data rates may apply. Message frequency varies. Text HELP for help. Text STOP to end. Terms and conditions. Privacy Policy.

2. Patient Insurance Information

Check Insurance Type*: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other ☐ None (skip to step 4)

Submit this form with a copy of our insurance card(s) (front and back) OR complete the information below.*

Primary Medical Insurance Co. | Phone

Policy/Medicare ID | Group ID

Policyholder's Relationship to Patient (if "self", skip next line)

Policyholder's Name & DOB (if not patient)

Secondary Medical Insurance Co. (if applicable) | Phone

Policy/Medicare ID | Group ID

Policyholder's Relationship to Patient (if "self", skip next line)

Policyholder's Name & DOB (if not patient)

Prescription Insurance Co

Policy ID | Group ID

PCN | BIN

Medicare Part D Plan Name (if applicable)

Medicare ID (HICN) or Medicare Beneficiary (MBI)

Medicare Part D Plan Address

Patient Name (First MI Last) Date of Birth

__ __ / __ __ / __ __ __ __

4. Patient Authorization

Please read the following carefully. If you agree, sign and date this Patient Authorization on page 4.

The PATHways® patient support program (the "Program") is available free of charge from Amneal Pharmaceuticals LLC. If you don't have a healthcare plan, or if your healthcare plan won't pay for your prescribed treatment, and you meet certain financial and medical standards, we will work with you and your physician(s) to find possible sources of financial assistance for your prescribed treatment.

Protected Health Information
Before we can begin the process of assisting you, we need to collect, use, and disclose your Protected Health Information (PHI). Protected Health Information includes any information related to your healthcare insurance or plan benefits, including coverage limits; all health records related to your treatment, including possible sensitive material relating to sexually transmitted diseases, mental health conditions, and/or genetic testing; and any information that has a bearing on your health or whether you're staying on your medicine or treatment. It may also extend to personal information such as your name, address, telephone number, Social Security number as well as health insurance member and group identification information. Although we are not looking for PHI that is unrelated to your treatment, it may be part of the health records sent to us.

When signed by you, this form permits your PHI to be released to the Program, Amneal Pharmaceuticals LLC, its affiliated companies, vendors, agents, collaboration partners and representatives (collectively "us" or the "Amneal Group") by you, your doctors, your healthcare plan or insurance company, your pharmacies, or others who might hold your PHI. Once you sign this form and it is sent back to us, we can use and disclose the released health information as needed to provide the support services described. We may also use your PHI to communicate with your healthcare providers and insurers about benefit, coverage and medical care, including compliance with Product treatments; locate a specialty pharmacy that can fill your prescription and facilitate dispensing of your prescription by such pharmacy; provide you with educational materials, information and services related to your treatment experience with the Products and your condition; contact you and leave messages about use of the Products and your medical care; verify, investigate, assist with, and coordinate your coverage for Products with your Insurers; coordinate prescription fulfillment; conduct surveys, data analytics, market research and other internal business activities related to the Program, Products or other Amneal Pharmaceuticals LLC products and programs; and contact you as otherwise required or permitted by law.

You do not have to sign this Authorization, but we cannot provide our services without it. You might need to pay for your product on your own, whether you sign this form or not. PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL US AT 866-4AMNEAL (866-426-6325).

By signing this form, I authorize my doctors, my healthcare plan or insurance company, and my pharmacies to release my PHI (as defined above) to the Amneal Group for the purposes set forth above. I understand that signing this Authorization is voluntary, but that without my signature I will not be able to participate in the Program. Further, non-participation in the Program will neither affect my healthcare treatment (including treatment with the Amneal product), nor my health insurance coverage.

I understand that once my doctors, healthcare plan, or pharmacies release my PHI pursuant to this Authorization, that information is no longer protected by Federal privacy laws (for example, HIPAA). However, the Amneal Group agrees to protect my PHI and to only use or disclose it for the purposes described in this Authorization or as permitted by law.

This Authorization allows those who rely on it to use and/or release my PHI for 1 year from the date I have signed it. I understand that I can withdraw the Authorization at any time by sending a written notice to the Amneal PATHways address listed below:

Amneal PATHways
P.O. Box 220303
Charlotte, NC 28222

Patient Name (First, MI, Last) Date of Birth

__ __ / __ __ / __ __ __ __

4. Patient Authorization (continued)

Please read the following carefully. If you agree, sign and date this Patient Authorization below.

My withdrawal goes into effect once it is received by the Program but will not affect uses and disclosures made prior to that date.

I am entitled to receive a copy of this Authorization after signing it below.

In addition to the authorization provided above for the disclosure of PHI for specific Program services described on page 1, I understand that Amneal Pharmaceuticals LLC also offers certain free patient services and product programs related to my therapy. I would like to take part in these programs and understand that these services are optional and my decision to participate or not in these additional programs will not impact the services for which I have authorized the disclosure and use of my PHI. These services may include communicating with me by mail, email, and phone, and such communications may include marketing materials and offers for product training and support, other services that may become available, or requests from Amneal Pharmaceuticals LLC for my participation in market research. I also understand that Amneal Pharmaceuticals LLC may share information from my participation in these programs with my healthcare provider. I authorize such uses and disclosures of my PHI under the same terms as stated in this Authorization. To withdraw my consent, I understand that I must contact the Program in writing at the address above. My withdrawal goes into effect once it is received by the Program. By signing below, I consent to these services and certify that I am at least eighteen (18) years of age.

Confidentiality

Confidentiality Notice: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

Signature* _____ Date* __ __ / __ __ / __ __ __ __

☐ I am the patient ☐ I am a legally authorized representative (complete fields below if checked)

Representative Name: _____

Relationship to Patient: _____

Patient Name (First, MI, Last)	Date of Birth
	__ __ / __ __ / __ __ __ __

5. HCP/Site of Care Information

Site of Care*: ☐ Infusion Center	☐ Hospital Outpatient	☐ Hospital Inpatient	☐ Provider Office	☐ Other
Prescriber Name (First, MI, Last)*			Prof. Designation*	
Practice/Facility Name*		Address*		
City*	State*		Zip Code*	
Individual NPI*	Organization NPI*			
Org Tax ID*	State License*		DEA*	
Office Contact's Name*		Fax*		
Office Contact's Phone*		Email*		

6. Diagnosis and Clinical Information

Has the patient started therapy? ☐ Yes ☐ No	
Primary Diagnosis/ICD Code*	Secondary Diagnosis/ICD Code
CPT Code	

7. Billing Office

Billing Office Address for Co-pay Payment (if different from HCP site information in section 5 above)

Office Name	Contact Name		
Address	City	State	Zip
Billing Phone	Fax		
Email			

8. Provider Attestation/Authorization

By signing below, I verify that the information provided in this PATHways® Patient 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 the PATHways® Patient Enrollment Form or to modify or discontinue any services of assistance provided through the PATHways® patient support program. Finally, I authorize Lash Group, LLC ("Lash Group") as my designated agent to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through the PATHways® program and (as applicable) to assess my patient's eligibility for copay assistance. My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Lash Group for purposes of the PATHways® program.

Provider Signature* _____ Date*__ __ / __ __ / __ __ __ __

*Indicates a required field

Patient Name (First, MI, Last)	Date of Birth
	__ __ / __ __ / __ __ __ __

9. Prescription Information

If administering provider information is the same as in section 5, skip to Patient Name field.

Prescriber Name (First, MI, Last)		Prof. Designation
Practice/Facility Name	Address	
City	State	Zip Code
Individual NPI	Organization NPI	
Org Tax ID	State License	DEA
Office Contact's Name	Fax	
Office Contact's Phone	Email	

Patient Name (First, MI, Last)*	DOB* __ __ / __ __ / __ __ __ __

Therapy*:

☐ Alymsys® (bevacizumab-maly)	◯ 100 mg/4 mL (25 mg/mL)	◯ 400 mg/16 ml (25 mg/mL)
☐ Releuko® (filgrastim-ayow)	◯ 300 mcg/0.5 mL Prefilled Syringes	◯ 480 mcg/0.8 mL Prefilled Syringes
☐ Fylnetra™ (pegfilgrastim-pbbk)	◯ 6 mg/0.6 mL Single-Dose Prefilled Syringe	
☐ Pemrydi RTU™ (pemetrexed injection)	◯ 100 mg/10mL Single-Dose Vials	◯ 500 mg/50mL Single-Dose Vials
☐ FOCINVEZ™ (fosaprepitant injection)	◯ 150 mg/50 mL (3 mg/mL) Single-Dose Vial	

Directions for Use*

Drug Allergies* ☐ No ☐ Yes (List medication[s]and associated reaction[s]):

Concomitant Medications*

10. Prescription Signature

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Lash Group, LLC, and its affiliates, agents, representatives and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

Provider Signature* _____ Date* __ __ / __ __ / __ __ __ __

☐ DAW - Please check DAW to ensure the specified therapy is dispensed as prescribed.