Sunovion Support®

PRESCRIPTION ASSISTANCE PROGRAM

sunovion
Innovation today, healthier tomorrows

To apply for help in affording your **Utibron™ Neohaler®** (indacaterol and glycopyrrolate) Inhalation Powder prescription, please mail completed application to:

Sunovion Support® Prescription Assistance Program ("Program")
PO Box 220285, Charlotte, NC 28222-0285

or **fax: (877) 850-0821**

Please see Important Safety Information, including **Boxed Warning** on pages 4 and 5 and enclosed full Prescribing Information.

Remember to include both your signature and that of your doctors, proof of income and the patient's prescription. If you have any questions or need help filling out this form, please contact us at (877) 850-0819 or visit **www.sunovionsupport.com**.

Patient Information

Name: _____

Date of Birth: _____ Phone: (____) _____ Gender: ☐ M ☐ F

Mailing Address: _____

City: _____ State: _____ Zip: _____

Is the patient a US resident (includes Puerto Rico)? ☐ YES ☐ NO

Is the patient 18 years of age or older? ☐ YES ☐ NO

If Patient has a legal guardian, please complete this section:

Legal Guardian(s) Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Household Income Information (legal guardian to complete if patient has one)

1. Number of people in household: ____ (include yourself, your spouse and any dependents)
2. What is total **GROSS ANNUAL** household income (including Social Security, Disability, Veterans, Wages, pension benefits, etc.)? $ _____
3. Did the patient/guardian file a Federal Income Tax Return for previous calendar year? ☐ YES ☐ NO

Please provide us with one of the following items to show total gross annual household income:

- Current paycheck stubs, proof of Social Security Income, 1099 or W-2 forms for all members of household
- Federal Tax Return (form 1040 or 1040EZ) for prior tax year

If the patient has not filed a Federal Tax Return, visit **www.IRS.gov** to request a free Verification of Non-Filing. Click on "Order a Transcript" or call (800) 908-9946. Use Form 4506-T and check box 7 to request verification of non-filing.

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Patient's Insurance Information

1. Is the patient enrolled in Medicare/Medicaid? ☐ YES ☐ NO

2. Does the patient have prescription drug coverage through any other benefit program that helps pay for prescription medicine, such as private insurance or VA or military benefits, including Medicare Part D? ☐ YES ☐ NO

If yes: please describe: _____

From the Healthcare Professional (to be completed by the doctor who is prescribing the medicine)

Healthcare Professional: _____

Site contact: _____ State License #: _____

Facility Name: _____

Phone: (____) _____ Fax: (____) _____

Street address: _____

City: _____ State: _____ Zip: _____

Prescription Information: Utibron™ Neohaler® (indacaterol and glycopyrrolate) Inhalation Powder

Please see Important Safety Information, including **Boxed Warning** on pages 4 and 5 and enclosed full Prescribing Information.

Dosage: ☐ 27.5mcg/15.6 mcg twice daily

Day Supply: ☐ 30 Days

Method of delivery:

☐ Patient will pick up prescription at retail pharmacy (will receive 30 day supply/ per fill only)

Number of Refills (max 11): _____

If there is a change in prescription or diagnosis of patient, Sunovion Support needs to be notified in writing.

ICD-10 Code (required information)

- ☐ J40 Bronchitis, not specified as acute or chronic
- ☐ J41 Simple and mucopurulent chronic bronchitis
  - ☐ J41.0 Simple chronic bronchitis
  - ☐ J41.1 Mucopurulent chronic bronchitis
  - ☐ J41.8 Mixed simple and mucopurulent chronic bronchitis
- ☐ J42 Unspecified chronic bronchitis
- ☐ J43 Emphysema
  - ☐ J43.1 Panlobular emphysema
  - ☐ J43.2 Centrilobular emphysema
  - ☐ J43.8 Other emphysema
  - ☐ J43.9 Emphysema, unspecified
- ☐ J44 Other chronic obstructive pulmonary disease
  - ☐ J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
  - ☐ J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified
  - ☐ J44.9 Chronic obstructive pulmonary disease, unspecified
- ☐ J47 Bronchiectasis

Your Consent is Required to Process Application

I acknowledge and agree that the above information is complete and accurate. I attest that I have no prescription insurance coverage, including Medicaid, Medicare or other public or private program, and I have insufficient financial resources to pay for the prescribed product. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient's Signature: _____ Date: _____

If Patient has a legal guardian, please complete this section:

Representatives Name: _____

Representatives Signature: _____ Date: _____

Describe relationship to Applicant: _____

Healthcare Professional Signature is Required to Process Application for the Sunovion Support Prescription Assistance Program

My signature below certifies that the person named in this form is my patient and medication received from the Program is only for that patient's use as indicated by the US Food and Drug Administration, and the information provided, to my knowledge, is accurate. I understand this Program is only for UTIBRON NEOHALER and it will not be offered for sale, trade, or barter. I agree that I will not submit any claim for reimbursement concerning the Product to Medicare, Medicaid, or any other third party, or return such Product for credit. I also agree that the Program has the right at any time to contact my patient, to modify or terminate the Program, and to recall or discontinue Product without notice. To the best of my knowledge, my patient does not have prescription drug insurance coverage (including Medicare, Medicaid, county funded, or other public programs) for the product being requested.

Healthcare Professional Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Healthcare Professional Signature: _____ Date: _____

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Important Safety Information and Indication for UTIBRON NEOHALER

Indication

UTIBRON™ NEOHALER® (indacaterol and glycopyrrolate) is a combination of a long-acting beta$_2$-agonist, or LABA, medicine (indacaterol) and an anticholinergic medicine (glycopyrrolate). UTIBRON NEOHALER is used long term, twice each day (morning and evening), to treat the symptoms of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema.

Important Safety Information

UTIBRON NEOHALER has been approved for COPD only and is NOT indicated for the treatment of asthma. People with asthma who take long-acting beta$_2$-adrenergic agonist (LABA) medicines, such as indacaterol (one of the medicines in UTIBRON NEOHALER), have an increased risk of death from asthma problems. It is not known if LABA medicines, such as indacaterol, increase the risk of death in people with COPD.

UTIBRON NEOHALER does not relieve sudden symptoms of COPD and should not be used more than twice daily. Always have a short-acting beta$_2$-agonist with you to treat sudden symptoms.

Use UTIBRON NEOHALER exactly as your health care provider tells you to use it. Do not use UTIBRON NEOHALER more often than it is prescribed for you.

Get emergency medical care if your breathing problems worsen quickly, you need to use your rescue medication more often than usual, or your rescue medication does not work as well to relieve your symptoms.

Do not use UTIBRON NEOHALER if you are allergic to indacaterol, glycopyrrolate, or any of the ingredients in UTIBRON NEOHALER. Ask your health care provider if you are not sure.

Tell your health care provider about all of your health conditions, including if you:

- have heart problems
- have high blood pressure
- have seizures
- have thyroid problems
- have diabetes
- have liver problems
- have kidney problems
- have eye problems such as glaucoma
- have prostate or bladder problems, or problems passing urine
- have any other medical conditions
- are pregnant or plan to become pregnant
- are breastfeeding or plan to breastfeed
- are allergic to UTIBRON NEOHALER or any of its ingredients, any other medicines, or food products. UTIBRON NEOHALER contains lactose (milk sugar) and a small amount of milk proteins. It is possible that allergic reactions may happen in people who have a severe milk protein allergy

Tell your health care provider about all the medicines you take, including prescription medicines, over-the-counter medicines, vitamins, and herbal supplements. UTIBRON NEOHALER and certain other medicines may interact with each other. This may cause serious side effects.

Especially tell your health care provider if you take:

- anticholinergics (including umeclidinium, tiotropium, ipratropium, aclidinium, glycopyrrolate)
- LABA medicines (including formoterol, salmeterol, vilanterol, indacaterol, olodaterol)

UTIBRON NEOHALER can cause serious side effects, including:

- sudden shortness of breath (that may be life-threatening) immediately after use of UTIBRON NEOHALER
- increased blood pressure
- fast or irregular heartbeat (palpitations)
- chest pain
- serious allergic reactions, including rash; hives; swelling of the tongue, lips, and face; and difficulties breathing or swallowing. Call your health care provider or get emergency medical care if you get any symptoms of a serious allergic reaction
- new or worsened eye problems, including acute narrow-angle glaucoma (symptoms may include eye pain or discomfort, blurred vision, red eyes, nausea or vomiting, seeing halos or bright colors around lights)

- new or worsened urinary retention (symptoms may include difficulty urinating, urinating frequently, painful urination, urination in a weak stream or drips)
- changes in laboratory blood levels, including high levels of blood sugar (hyperglycemia) and low levels of potassium (hypokalemia), which may cause symptoms of muscle spasm, muscle weakness, or abnormal heart rhythm

Common side effects of UTIBRON NEOHALER include sore throat and runny nose, high blood pressure, and back pain.

These are not all of the possible side effects with UTIBRON NEOHALER. Tell your health care provider about any side effect that bothers you or that does not go away.

Do not swallow UTIBRON capsules. UTIBRON capsules are for inhalation only with the NEOHALER device. Never place a capsule in the mouthpiece of the NEOHALER device.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

This information is not comprehensive.

How to get more information:

- Talk to your health care provider
- Visit www.UTIBRON.com to obtain the FDA-approved product labeling
- Call **1-888-394-7377**

For additional information, please visit www.sunovionsupport.com for full Prescribing Information, including BOXED WARNING and Medication Guide, for UTIBRON NEOHALER.

Authorization and Consent to Share and Disclose Health Information with the Sunovion Support Prescription Assistance Program ("Program")

Please read and sign this form so that you or the person for whom you are assisting may be able to participate in the Program.
Please note "I" is defined as the potential Participant.

- I acknowledge and agree that all the information I provide in connection with my application to the Program will be used to decide if I qualify for the Program.
- By signing below, I verify that the information on my application, including a copy of my proof of income documentation, is complete and accurate.
- I do not have any other coverage for prescription medications, including Medicaid, Medicare, or any public or private assistance programs or any other prescription insurance.
- I understand that any changes to my financial, prescription drug coverage, diagnosis, or insurance information may affect whether I am able to continue to participate in the Program. I agree to contact the Program to inform them of any changes to my income, prescription drug coverage, diagnosis, or insurance information.
- I allow my healthcare provider(s), my pharmacy(ies), and my health plan or insurers, to give medical information relating to my use or need for product(s) provided under the Program to The Lash Group, Inc. The Lash Group runs the Program on behalf of Sunovion Pharmaceuticals Inc. My medical information can include spoken or written facts about my health and payment benefits. It can include copies of records from my health provider, pharmacy, or health plan about my health or healthcare.
- People who work for The Lash Group and the Program may see my information, but they may use it only to help me get assistance to receive my Sunovion medication, to determine whether I qualify for the Program, to operate the Program, or as otherwise required or permitted by law.
- I allow The Lash Group and the Program the right to verify and to evaluate any financial documentation, insurance information, and medical records submitted to the Program to determine if I qualify for the Program and to operate the Program.
- I understand that The Lash Group and the Program have the right to contact me directly to confirm receipt of medications [or to obtain my feedback about the Program] and that the Program can revise, change, or terminate the Program at any time.
- I understand that I may cancel my permission and withdraw from this Program at any time.
- I understand that if I cancel my permission I can tell my healthcare provider, my pharmacy, and my insurer in writing that I do not want them to share any more information with The Lash Group and the Program, but it will not change any actions they took before I told them and it will terminate my participation in the Program.
- This authorization and consent will last for up to12 months.
- I know that I have a right to see or copy the information my health care providers, my pharmacy, or insurers have given to The Lash Group and the Program.
- I understand that I am free at any time to switch my healthcare provider and it will not affect eligibility for financial assistance. This Program is offered to me regardless of any healthcare provider or pharmacy I use.
- I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers, pharmacies, or insurers treat me. If I refuse to sign this form, I know that this means I will not be eligible to participate in the Program.
- I understand that signature of a legal guardian or parent is required for all minor applicants and those patients who are unable to sign.

Applicant Signature: _____ Date: _____

Applicant Name: _____

If you are unable to sign a legal guardian must sign.

Representative's Name: _____ Date: _____

Representative's Signature: _____ Describe relationship to Applicant: _____

If someone helped you with the application and you want them to answer questions for you, please give us their name and phone number:

Name: _____ Phone: (____) _____