XHANCE PATIENT FINANCIAL ASSISTANCE ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: _____ Sex: ☐ Male ☐ Female

DOB: ____/____/_____ (Date of Birth: MM/DD/YYYY)

☐ HOME ☐ CELL ☐ WORK Phone: _____

☐ HOME ☐ CELL ☐ WORK Phone: _____

Email: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Do you personally reside in the US or Puerto Rico? ☐ YES ☐ NO

Do you have a prescription for XHANCE™? ☐ YES ☐ NO

PATIENT INSURANCE INFORMATION

If the patient has insurance, please check all that apply: ☐ Commercial/Private Insurance

☐ Insured with no Rx Coverage ☐ Uninsured ☐ Healthcare Marketplace Plan

Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Advantage

Medicaid: ☐ Actively Enrolled ☐ Applied/Pending ☐ Denied (provide letter) ☐ Never Applied

Medical Insurance Company	Prescription Drug Plan Name (if different than medical insurance)	Other ☐ Secondary/Supplemental ☐ Veterans Affairs Benefits ☐ State Pharmaceutical Assistance Program
Name of Insured (cardholder)		
Policy # / Group #	Policy # / Group #	Policy Name
Plan Phone	Name of Insured (cardholder)	Policy Phone
Member ID #	Plan Phone	Policy #

Please copy front and back of medical insurance and prescription drug plan cards and include with fax or email.

HEALTHCARE PROFESSIONAL/FACILITY INFORMATION

Physician Name: _____

Facility Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT FINANCIAL INFORMATION (Required for Financial Assistance)

Patient may be subject to verify their gross annual household income. Income must reflect amount for entire household.

Please indicate your household size based on IRS Form 1040 or 1040 EZ (number of persons dependent upon total household income): _____

Please indicate your household's Adjusted Gross Income as it appears on the most recent year's federal tax return: $ _____

Please attach a copy of the most recent year's federal tax return (IRS Form 1040 or 1040 EZ) as well as the W2 form(s) that document your household income, or other verifiable financial statements and information. Please note that household income also includes alimony, child support, Social Security, pension or retirement payments, unemployment benefits, workers' compensation, and/or disability payments your receive.

ACKNOWLEDGEMENT OF TERMS AND CONDITIONS

I verify that I meet the eligibility requirements and that the information provided on this application is complete and accurate. I agree that I will notify OptiNose US, Inc. if my financial information or insurance coverage changes. I certify that no part of the cost of EXHANCE is or will be covered or reimbursed by a federal or state healthcare program, including but not limited to Medicaid and Medicare. I agree that I will not submit any claims to insurance for reimbursement for my prescriptions covered under the Patient Assistance Program. I understand and agree that any assistance I receive under the Patient Assistance Program will not count towards my true-out-of-pocket costs (TrOOP) as defined under the Medicare Modernization Act.

I understand that the EXHANCE Patient Assistance Program may request documentation to verify financial or insurance information and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that OptiNose US, Inc. reserves the right at any time and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the EXHANCE Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

I authorize my healthcare providers and health plans to disclose personal and medical information about me to OptiNose US, Inc. and its agents and contractors, and I authorize OptiNose US, Inc. to use, share and disclose this information to third parties to: 1) establish my benefit eligibility; 2) provide support services, including facilitating the provision of OptiNose US, Inc. medication to me; and 3) contact me to evaluate therapy and the effectiveness of the program.

PATIENT SIGNATURE: _____ DATE: _____

OptiNose, Inc. understands that your privacy is important. By providing your name, address, and other requested information, you are giving OptiNose US, Inc., and other parties working with us, permission to communicate with you about XHANCE or other products, services, and offers from OptiNose US, Inc. We will not sell your name or other personal information to any party for its marketing use. To view the privacy policy, please visit **https://www.optinose.com/privacy-policy**

For any questions and concerns about the program, please call a customer service representative at: 1-833-942-6231

The completed application can be submitted by Fax, Email or by Mail to:

XHANCE Patient Assistance
2325 Heritage Center Drive,
Furlong, PA 18925

Fax: 1-800-784-9950
Email: optinosepap@msmpatientservices.com

To report an adverse event to XHANCE, please contact OptiNose at 1-833-678-6673 .