

## How to Apply for Participation in the Patient Assistance Program

Physician can initiate a request for patients for participation in the Patient Assistance Program by:

### 1. E-PRESCRIPTION

- a. ASPN Pharmacies, LLC  
290 West Mount Pleasant Ave  
Building 2, 4th Floor, Suite 4210  
Livingston, NJ 07039  
NPI: 1538590690

### 2. FAX

- a. Fax a completed and signed Prescription Enrollment Form or prescription along with the required documentation to 866-515-0970

### 3. MAIL

- a. ASPN Pharmacies, LLC  
290 West Mount Pleasant Ave  
Building 2, 4th Floor, Suite 4210  
Livingston, NJ 07039

## Patient Requirements & Eligibility

1. Legal resident in the USA
2. Have a gross household income less than or equal to 300% of the Federal Poverty Level based on household size.
3. Uninsured or functionally uninsured
  - a. No prescription drug insurance; or
  - b. Have health insurance, but there is no coverage for the prescribed Biohaven product, provided that the patient has exhausted all appeal options and there is a letter documenting such; or
  - c. Out of pocket costs for Nurtec exceeds the entire cost of the medication; or
  - d. Commercially insured patients who's documented patient health insurance OOP expenses, related to Nurtec only, exceeds \$2450 per year after assistance is applied; or
  - e. Health insurance plan is grandfathered within the meaning of the Patient Protection and Affordable Care Act of 2010 and the patient has exceeded a cap on the prescription drug coverage, or there are other barriers to coverage of the prescribed Biohaven product.
4. Patient must provide a Social Security Number to conduct a soft credit check to determine patient eligibility.
5. Patient can also provide one of the following document(s) if a soft credit check is not possible:
  - a. Federal Tax Return
  - b. W-2
  - c. 1099 Form
  - d. Unemployment Award Letter
  - e. Social Security Income
  - f. Disability Statement
  - g. Pension Statement
  - h. Last two (2) recent paystubs
  - i. Unemployment documentation
  - j. Letter from physician or social worker on company letterhead attesting to lack of income

If you have any questions about the BioHaven Patient Assistance Program, please contact the BioHaven Patient Assistance Program at 1-866-473-0088, Monday through Friday, 8:30 AM–8:00 PM ET.

## Patient Assistance Program Form

Phone: (866)-473-0088

Fax: (866)-515-0970

### Patient Information

FIRST NAME:	LAST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH (MM/DD/YYYY):	GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
EMAIL:		
PHONE:	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
SSN:	I AM A RESIDENT OF THE U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOUSEHOLD SIZE:		

### Patient Representative (if applicable)

I permit the BioHaven Patient Assistance Program to speak and write to the following person(s) about this form, and I permit the person(s) to sign any documents related to the program on my behalf:

FIRST NAME:	LAST NAME:
RELATIONSHIP TO PATIENT:	TELEPHONE:

### Prescription Information

DRUG: <b>Nurtec™ ODT orally disintegrating tablets 75mg</b>	DATE:
QUANTITY:	REFILLS:
DIRECTIONS:	

### Prescriber Information

FIRST NAME:	LAST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP:
NPI:		
PHONE:	FAX:	

### Prescriber Attestation

By my signature below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment.

PRESCRIBER SIGNATURE \_\_\_\_\_ (DISPENSE AS WRITTEN)

DATE OF SIGNATURE \_\_\_\_\_

### Insurance Information

DO YOU HAVE PUBLIC OR PRIVATE INSURANCE:

Yes  No

If yes, please provide the information below and provide a **copy of the front and back of your insurance card**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ID#:	POLICY#:
TELEPHONE:	DO YOU HAVE MEDICAID/MEDICARE? <input type="checkbox"/> Yes <input type="checkbox"/> No

ARE YOU MEDICARE PART D ENROLLED OR ELIGIBLE?

Yes, enrolled  Yes, eligible  No

DO YOU HAVE OTHER STATE/GOVERNMENT FUNDED COVERAGE (ADAP,SPAP)?

Yes  No

I attest that the above information is complete and accurate. I attest that I have no or insufficient prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. I understand and agree that PAP medication received will not count toward my true-out-of-pocket costs (TROOP) as defined under the Medicare Modernization Act. I understand that the PAP medication will be shipped to my physician for my pick-up or will ship directly to my home and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the PAP medication to any third party, including my Medicare Part D Plan. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

PATIENT OR LEGAL GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_