AUCTA PHARMACEUTICALS

Motpoly XR™ (lacosamide) extended-release capsules C-V

AUCTA PATIENT ASSISTANCE PROGRAM (PAP)

Send completed, signed, and dated application to: **KnippeRx**

Fax: (877) 402-2719

Phone: (888) 656-0126

PROGRAM INFORMATION

As part of its commitment to patients and health care providers, the AUCTA Pharmaceuticals Inc. Patient Assistance Program (PAP) provides select Aucta branded products free of charge to patients who cannot afford their medication due to no coverage or insufficient insurance coverage.

Applying to PAP is ***FREE***. AUCTA PAP is not associated with any individuals or organizations who may charge patients a fee to assist them in completing enrollment forms for PAP. These individuals or organizations are acting independently of AUCTA PAP, and do not have AUCTA PAP's consent.

To be eligible for PAP, both the prescribing health care professional AND the patient must complete, sign, and date this program application and certify that:

1. The patient is under the care of a licensed US physician and has a valid prescription for the eligible Aucta branded product.
2. The patient currently resides in the United States and is 18 years of age or older.
3. The patient cannot afford to pay for the eligible Aucta branded product and the PAP can verify that the patient meets the PAP's financial eligibility criteria.

PROGRAM CHECKLIST

1. Both the patient and the prescribing health care professional must complete all appropriate sections of this application and sign and date in all designated places.
2. The patient must provide PAP with valid proof of their current gross annual household income (household income before taxes are withheld) by including with this application, a COPY of **ONE** of the following documents showing proof of the household income the patient provided on the application form:
    - Most recent Federal or State Tax Return Forms 1040/1040EZ
    - Most Recent IRS-W2, or 1099 Forms
    - The two most current paycheck stubs or earning statements, or other income statement(s)
    - Social Security income, pension, unemployment benefits statement, or other income statement(s)
    - If no income, Letter of Attestation

    Include a COPY of any **ONE** of these documents with your completed, signed, and dated application. **Please do not send an original document.**
3. Dispensing ***Motpoly XR lacosamide extended-release capsules (C-V)*** requires a Government Issued Photo ID on file. Please include a copy of your ID along with your application.
4. Dispensing ***Motpoly XR lacosamide extended-release capsules (C-V)*** to residents in the state of Kentucky requires that the dispensing pharmacy collect the social security number of the patient receiving the prescription. If you reside in Kentucky, please include your social security number.
5. Fax your completed, signed, and dated application, along with one document to verify your proof of the household income. Fax your completed application to (877) 402-2719
6. Prescribers will send an electronic prescription (eRx) to the pharmacy via a valid eRx platform, unless holding an eRx exemption. Prescribers with a valid eRx exemption may call the pharmacy to provide a verbal prescription to a pharmacist. When sending eRx, please search for KnippeRx in Charlestown, IN, 47111, NPI # 1285159152.
7. Patient's current medications, allergies and health conditions must be included in section 2

AUCTA PATIENT ASSISTANCE PROGRAM APPLICATION

PATIENT MUST COMPLETE THIS SIDE OF APPLICATION AND SIGN IN ALL PLACES SIGN HERE

SECTION 1: COMPLETE THE PATIENT INFORMATION BELOW. PLEASE PRINT IN LEGIBLE CAPITAL LETTERS.

USE A BLACK OR BLUE PEN

Patient's First Name _____ US Resident* Yes _____ No _____

Patient's Last Name _____ Social Security Number _____

Address Line 1 _____

Address Line 2 (Apartment/Unit Number) _____

City _____ State _____ Zip _____

Date of Birth _____ I am enrolling for the first time. _____ I am re-enrolling. _____

Provide an email address and a mobile phone number so we may contact you with program notifications and updates.

Mobile Phone _____ Home Phone _____

Email _____

Provide current gross annual household income (your income before taxes), including Social Security and pension benefits.

Total Gross Annual Household Income $ _____

Number of Household Members (Including Patient) Who Depend on This Income ____

Do you have insurance or other prescription drug coverage? YES ■ NO ■

Are you enrolled in any of the following? ■ Medicare ■ Medicaid ■ Medicare Part D ■ Other

I would like my product shipped to: ■ My Home ■ My Physician's Office

■ Other Address: _____

Special delivery instructions: _____

Section 2: Declarations and Authorization

Applicant Declarations and Authorization

I certify that all the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for this program. I certify that I cannot afford this medication. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription, or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that AUCTA Patient Assistance Program (PAP) reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I understand that AUCTA PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application. I authorize AUCTA PAP and its affiliates to forward this prescription to a dispensing pharmacy on my behalf.

AUCTA PAP is not responsible for verifying any information contained in Section 2, including, without limitation, allergies, medical conditions, or other medications being taken by me. With respect to this application, I understand that only the dispensing pharmacy will be responsible for the information contained in Section 2 of this application form. I understand that assistance received through the AUCTA PAP is not insurance.

- List all medications currently being taken. Please include prescription medications, over the counter medications and supplements:

- List known drug allergies below:

- List other known health conditions below:

Applicant Authorization for Use and Disclosure of Personal Health Information

By signing below, I authorize my health care provider(s) and my health plan(s), including Medicare, to disclose to the AUCTA Patient Assistance Program and other individuals involved in administering the AUCTA Patient Assistance Program (collectively, the "PAP") my personal health information, including the information provided by my health care provider on the PAP Application form and other information related to my participation in the PAP (collectively, "My Information"), so that the PAP may use the information to (i) assess my qualification for the PAP, (ii) provide me with PAP assistance,
(iii) administer the PAP, (iv) monitor, audit, assess and evaluate the PAP's implementation and effectiveness, and (v) contact me via mail, email, text message, phone, or fax for PAP-related purposes, including as part of PAP audits and to request additional information from me. I authorize the PAP to use My Information for the foregoing purposes, as well as to disclose My Information to auditors of the PAP and to my health plan(s), including Medicare, so that I may receive assistance from PAP if I am eligible. I understand that My Information, once disclosed pursuant to this authorization, may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the PAP intends to use and disclose My Information only for the purposes stated herein. I understand that I do not need to sign this Authorization in order to receive health care treatment. or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the PAP. I further understand that I may cancel the Authorization at any time by sending a written notice of cancellation by mail to: AUCTA Patient Assistance Program PO Box 991624, Louisville, KY 40269]. I understand that if I cancel the Authorization, that will not invalidate uses and disclosures of My Information made in reliance on the Authorization before the PAP received notice of my cancellation. If I do not cancel it, the Authorization will remain in effect for 15 months from the date of my signature below (or the maximum period allowed by applicable state law, if less than 15 months). I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

SIGN HERE Patient's Original Signature _____ Date M M D D Y Y Y Y

Section 3: Physician/Prescriber Information

Prescriber's First Name _____ M.I._____

Prescriber's Last Name _____

Prescriber's Address:_____

City:_____ State:_____ Zip Code:_____

Prescriber's Phone:_____ Prescriber's Fax:_____

Office Contact Person:_____

Physician/Prescriber
NPI Number _____

Please Indicate:

Drug	Check to indicate strength	Quantity (per month)
Motpoly XR 100mg (60 capsules per bottle)	☐	
Motpoly XR 150mg (60 capsules per bottle)	☐	
Motpoly XR 200mg (60 capsules per bottle)	☐	

Physician/Prescriber Attestation

I certify that this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize AUCTA PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient. I understand that AUCTA PAP reserves the right to modify or discontinue this program at this facility/practice or terminate assistance at any time and without notice. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. I understand that AUCTA PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application as it relates to AUCTA PAP for the purpose of determining eligibility of the patient.

SIGN HERE Physician/Prescriber's Original Signature _____ **Date** M M D D Y Y