

## Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program (MEPAP)

### POLICIES AND PROCEDURES

Thank you for your interest in the Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program ("MEPAP"). To participate in the program, you must meet the eligibility criteria set forth below. It is important that you provide all required information and sign the application where indicated. Incomplete or incorrect applications will delay the application process, so please ensure all information is provided within 60 days. If all required information is not received within 60 days, your application cannot be approved.

#### Patient

- The patient must be a U.S. citizen or a legal resident living in the United States.
- The patient's gross yearly household income must fall below 400% of the current Federal Poverty Guidelines, based upon family size. Verification documents will be required.
  - Approved Verification Documents: 1040; 1040ez; W2; 4506-T; SSI Statement; Disability Statement; Statement from Physician, Nurse, or Patient Advocate; or Certified Notarized Statement from the Applicant.
- The patient must meet one of the following:
  - The patient must not have any prescription insurance coverage, including, without limitation, coverage through Medicaid, Medicare (including Parts A&B, Medicare Advantage, or Part D), TriCare, a qualified health plan purchased on a state-based, partnership, or federally-facilitated Exchange, or any other public or private program or insurer. Verification documents will be required.
    - Approved Verification Documents: Denial Letter; Termination Statement; Statement from Physician, Nurse, or Patient Advocate; or Certified Notarized Statement from the Applicant.
  - The patient has commercial prescription drug coverage only for generic products and the patient must not have prescription insurance coverage through any state or federally funded program, including, without limitation, Medicare (including Parts A&B, Medicare Advantage, or Part D), Medicaid, or TriCare. Verification documents will be required.
    - Approved Verification Documents: Denial Letter; Termination Statement; Statement from Physician or Nurse, or Verification of Applicant's Coverage from Insurer.
- The patient must certify that he/she will not submit a claim for any payment for the free product or resell, trade, barter or return for credit any free product received from MEPAP.

#### Physician

- The physician must complete, sign, and submit the MEPAP Application acknowledging that the patient has been prescribed EpiPen® (epinephrine injection, USP) Auto-Injector and is in need of assistance.
  - Product will not be shipped to a patient's home or to a P.O. Box.
- The physician must certify that he/she will call the Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program at 800.796.9526 if the patient's prescription insurance coverage changes, if the patient's dosage changes, or if the patient discontinues therapy.
- The physician must certify that he/she will not submit a claim for any payment for the free product or resell, trade, barter or return for credit any free product received from MEPAP.

Completed forms and required documentation for the Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program should be emailed, mailed, or faxed to:

Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program  
781 Chestnut Ridge Road  
Morgantown, WV 26505  
Fax: 1-877-427-7290  
Email: [MylanPAP@mylan.com](mailto:MylanPAP@mylan.com)

If the applicant is approved for the program, medication will be shipped to the physician's office to be dispensed to the patient free-of-charge. Once approved, the application will be eligible to receive replenishment medication (as prescribed by the patient's physician) for up to one year. A Replenishment Authorization Form will need to be filled out by the patient's physician and returned to the Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program in order to receive the next replenishment. Please note that replenishment request will be considered on an as needed basis. Please check with your healthcare professional(s) prior to placing any replenishment requests. Applicants must re-apply annually.

Additional information about the Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program is available by calling 800.796.9526.

*Mylan reserves the right to discontinue or modify this program at any time.*



781 Chestnut Ridge Road Morgantown, WV 26505  
 Phone: 1.800.796.9526 Fax: 1.877.427.7290  
 Email: MylanPAP@mylan.com

**Mylan EpiPen® (epinephrine injection, USP) Auto-Injector  
 Patient Assistance Program (MEPAP)**

*Please print clearly in blue or black ink*

**(SECTION 1) PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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Mailing Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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Social Security Number: \_\_\_\_\_ Gender Male/Female: \_\_\_\_\_ Preferred Daytime Telephone: \_\_\_\_\_

**(SECTION 2) PATIENT ELIGIBILITY INFORMATION**

*ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME & LACK OF APPLICABLE INSURANCE VERIFICATION (REQUIRED)*

**GROSS ANNUAL HOUSEHOLD INCOME** (Including all Income, Wages, Social Security, Pension, Disability, Unemployment Benefits, Financial Assistance, etc.)

Does the patient meet the income requirements of gross yearly household income below 400% of the current Federal Poverty Guidelines? Yes  No

If "No", the patient is not eligible.

Number of people in household: \_\_\_\_\_ \$ \_\_\_\_\_ Monthly \$ \_\_\_\_\_ Annual

**LACK OF APPLICABLE PRESCRIPTION DRUG COVERAGE**

Is the patient currently enrolled in any state or federal prescription coverage including, without limitation, Medicare, Medicaid, or TriCare? Yes  No

Does the patient have any commercial prescription insurance coverage? Yes  No

If yes, does the commercial prescription insurance only cover generic drugs? Yes  No

Is the patient a U.S. Citizen or legal resident living in the United States? Yes  No

**(SECTION 3) PATIENT AUTHORIZATION FOR INFORMATION USE AND DISCLOSURE**

I request and authorize my healthcare professionals and health insurers to disclose to Mylan Specialty, Mylan Institutional Inc., Mylan Pharmaceuticals Inc., and their affiliated companies (collectively, "Mylan") my "Protected Health Information" ("PHI"), as this term is defined under the Health Insurance Portability and Accountability Act of 1996 and its various implementing regulations, as amended ("HIPAA"), so that Mylan may use the information to determine my eligibility for insurance coverage for Mylan EpiPen® (epinephrine injection, USP) Auto-Injector and to administer my participation in the Mylan EpiPen® (epinephrine injection, USP) Auto-Injector Patient Assistance Program ("MEPAP"). I understand that once disclosed pursuant to this Authorization, my PHI may no longer be protected by federal law and could be re-disclosed to others, but I also understand that Mylan intends to safeguard my PHI and to use and disclose it only for the purposes described herein. I understand that I do not need to sign this Authorization in order to receive healthcare treatment or insurance benefits, and that I may cancel this Authorization at any time by sending a written notice of cancellation by mail to MEPAP Opt-Out Administrator, 781 Chestnut Ridge Road, Morgantown, WV 26505, or by fax to 1-877-427-7290. If I do not cancel it, this Authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this Authorization when it is signed.

\_\_\_\_\_  
 [Name of Patient] [Signature] [Date]

\_\_\_\_\_  
 [Name of legal representative] [Signature] [Date]

If signed by Representative, describe the nature of relationship with patient:

\_\_\_\_\_



**(SECTION 4) PATIENT CERTIFICATION**

I certify that the information detailed on this form is indeed complete and accurate. As noted above, I attest that I either have a) no prescription insurance coverage, including, without limitation, coverage through Medicaid, Medicare (including Parts A&B, Medicare Advantage, or Part D), TriCare, a qualified health plan purchased on a state-based, partnership, or federally-facilitated Exchange, or any other public or private program or insurer, or b) commercial prescription drug coverage only for generic products and I do not have coverage through any state or federally funded program including, without limitation, Medicare (including Parts A&B, Medicare Advantage, or Part D), Medicaid, or TriCare. I attest I have insufficient financial resources to afford the prescribed medication, and I meet the MEPAP income eligibility criteria. Additionally, I agree that at any time during my enrollment, the [MEPAP] may request additional documentation to authenticate the statements made on my application. I certify that I will not resell, trade or barter, or return for credit any product received from the MEPAP, nor will I submit an insurance claim or other claim for payment for any product received from the MEPAP. I understand and acknowledge that MEPAP assistance may be temporary and that this program may be changed or discontinued at any time without notice.

[Name of Patient]	[Signature]	[Date]
[Name of legal representative]	[Signature]	[Date]

If signed by Representative, describe the nature of relationship with patient:

**(SECTION 5) PHYSICIAN INFORMATION**

*TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER*

First Name:	MI:	Last Name:	Professional Designation:
State License #:	Facility Name:		
Shipping Address: (Cannot be shipped to the patient or P.O. Box)			
City:	State:	Zip Code:	
Contact Name:	Telephone Number:	Fax Number:	
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**MANDATORY SUBSECTION FOR ALL OHIO BASED PHYSICIANS**

Under Ohio law, Mylan Specialty L.P, which holds wholesale distributor license number WVMF.012304150-03 (expiring June 30, 2018), may only provide prescription drugs to prescriber's whose practice is licensed as a Terminal Distributor of Dangerous Drugs ("TDDD") or is exempt from such licensure under Ohio Revised Code ("ORC") § 4729.541. A TDDD license allows a business entity, including prescriber practices, to receive, purchase, and possess prescription drugs and controlled substances, for distribution to patients. Not all prescriber practices, however, are required to obtain a TDDD license. For example, subject to certain exceptions, an individual prescriber doing business as a sole proprietor (not incorporated in any manner) or a practice that is a corporation, limited liability company, or professional association where a prescriber is the sole shareholder and is authorized to provide the professional services being offered by the practice are exempt from obtaining a TDDD license. For a complete list of exemptions, please refer to section 4729.541 of the ORC. For more information on TDDD licensing requirements for prescribers, please visit the Ohio Board of Pharmacy website at [www.pharmacy.ohio.gov/PrescriberTDDD](http://www.pharmacy.ohio.gov/PrescriberTDDD). The above information is being provided for your convenience and is not offered as, nor should it be construed as, legal advice.

Please select and complete one of the following:

- The practice at which I work, [insert name] \_\_\_\_\_, located at the address I provided above, has an active TDDD license that allows me to receive and store the requested product at this location. The TDDD license number is \_\_\_\_\_ and expires on \_\_\_\_\_.

OR

- The practice at which I work, [insert name] \_\_\_\_\_, located at the address I provided above, is subject to one of the TDDD licensing exemptions in ORC § 4729.541.



781 Chestnut Ridge Road Morgantown, WV 26505

Phone: 1.800.796.9526 Fax: 1.877.427.7290

Email: MylanPAP@mylan.com

By signing below, I warrant that the information provided above is complete and accurate and attest that I can receive and store the requested product at the address I provided because I hold an unrestricted, active TDDD license or my practice is exempt from obtaining a TDDD license under ORC § 4729.541.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(SECTION 6) PRESCRIPTION INFORMATION AND PHYSICIAN CERTIFICATION**  
*PLEASE ATTACH A COPY OF THE PATIENT'S PRESCRIPTION*

Mylan EpiPen® (epinephrine injection, USP) Auto-Injector 0.3 mg/0.3 mL	2 Pak <input type="checkbox"/>	Quantity _____
Mylan EpiPen® (epinephrine injection, USP) Auto-Injector 0.15 mg/0.3 mL	2 Pak <input type="checkbox"/>	Quantity _____

I certify that I have prescribed Mylan EpiPen® (epinephrine injection, USP) Auto-Injector for the patient identified in Section 1 and that this medication is medically necessary for the patient. I certify that all information I have provided about this patient is complete and accurate, and I understand that the MEPAP and/or its agents are relying on this information to determine patient eligibility. To the best of my knowledge, the patient either has a) no prescription insurance coverage, including, without limitation, coverage through Medicaid, Medicare (including Parts A&B, Medicare Advantage, or Part D), TriCare, a qualified health plan purchased on a state-based, partnership, or federally-facilitated Exchange, or any other public or private program or insurer, or b) commercial prescription drug coverage only for generic products and does not have coverage through any state or federally funded program including, without limitation, Medicare (including Parts A&B, Medicare Advantage, or Part D), Medicaid, or TriCare. The patient has insufficient financial resources and meets the MEPAP income eligibility criteria. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the free product provided by the MEPAP. I understand that MEPAP reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from MEPAP will not be resold or offered for sale, trade or barter, and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by MEPAP, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand MEPAP reserves the right to recall or discontinue product at any time without notice.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(SECTION 7) FINAL CHECKLIST**

Before returning this application, please ensure the following have been completed:

- Patient or legal representative has completed and signed the application (Sections 1-4)
- Physician has completed and signed the Physician Information, Mandatory Subsection for Ohio Based Physicians (if applicable), and Prescription Information and Physician Certification sections (Sections 5 & 6)
- A copy of the patient's prescription has been attached (Section 6)
- Copies verifying current financial status have been attached (Please do not send original documents)
- Copies verifying lack of applicable prescription drug coverage have been attached (Please do not send original documents)