endo ADVANTAGE™ Committed to Access

Patient Assistance Program Application

PHYSICIAN INFORMATION

Physician Name

Practice Name

Practice Address (no P.O. boxes)

City State ZIP

Contact Person

Contact Phone # Fax #

Phone Type ☐ Main ☐ Direct ☐ Mobile Alternate Phone #

Contact Email

Endo Advantage™ ID #

CLINICAL INFORMATION

Anticipated initial injection Date

Diagnosis: ICD-10:

PHYSICIAN CERTIFICATION

My signature below certifies (1) that the person named on this form is my patient and that XIAFLEX® (collagenase clostridium histolyticum) received in response to this application is only for the use of the patient named on this form; (2) that this medication will not be offered for sale, trade, or barter; (3) that no claim for reimbursement of either XIAFLEX® or related medical procedures and services will be submitted to Medicare, Medicaid, or any third party; (4) that XIAFLEX® will not be returned for credit; (5) that Endo Pharmaceuticals Inc. has the right to contact my patient directly to confirm receipt of XIAFLEX®, and to revise, change, or terminate this program at any time; (6) that to the best of my knowledge my patient meets the criteria for the Endo Advantage™ Patient Assistance Program; and (7) that the information provided in this application is complete and accurate.

Physician Signature _____ Date

PATIENT INFORMATION

First Name MI

Last Name DOB

Address

City State ZIP

Daytime Phone # Alternate Phone #

Total Household Income Total # of Dependents

ELIGIBILITY AND TREATMENT INFORMATION

Insurance: Patient is uninsured (no third-party or private insurance) ☐ Yes ☐ No

Residency: US resident or permanent citizen ☐ Yes ☐ No

Income documentation attached (1040, 1040EZ, SSI Letter, SSDI, IRS-4506-T, Notarized Letter) ☐ Yes ☐ No

XIAFLEX® collagenase clostridium histolyticum

PLEASE FAX THIS COMPLETED FORM TO:
1-800-939-3348

CALL US:
Phone: 1-800-743-2382

Please click here for full Prescribing Information, including Boxed Warning and Medication Guide.

PATIENT CERTIFICATION AND CONSENT

I would like to receive XIAFLEX® (collagenase clostridium histolyticum) at no charge through Endo Advantage™. I understand that all the information I provide in connection with this application will be used to determine my eligibility to participate in the Endo Advantage™ Patient Assistance Program.

I certify that I do not have coverage for prescription drugs under Medicare, Medicaid, or any other public or private insurance plan, nor am I able to receive XIAFLEX® under any other assistance program.

I understand that Endo Pharmaceuticals Inc., the sponsor of Endo Advantage™, reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. I also understand that although XIAFLEX® may be given to me at no charge now, this does not mean I will be entitled to receive it at no charge indefinitely.

I consent to the release and disclosure of personal information, including my medical records, name, Social Security number, address, and date of birth to Endo Pharmaceuticals Inc., its agents, distributors, or other designated representatives who may need my personal information to process this application, assure continuity of care, and in order for me to receive XIAFLEX® at no charge. I hereby expressly authorize my physician to release to Endo Advantage™ all information that may be required in connection with this application. I also authorize Endo Advantage™, Endo Pharmaceuticals Inc., and their agents to release medical information and related information to each other in order for me to receive XIAFLEX®. I understand that this information will not be used for any other purpose unless I give written consent, the government requires it, or Endo Advantage™ removes my name and any other identifying information.

I understand that the information to be disclosed hereunder, once shared with others, will not be protected by state and federal privacy laws, provided that it is used and disclosed solely for the purposes stated above.

I understand that my pharmacy provider may receive remuneration from Endo in exchange for health information and/or for therapy support services provided to me.

I understand that this authorization is voluntary and that if I do not sign it, my ability to obtain treatment from my physician or obtain insurance benefits will not be affected; however, I will not be eligible to receive the services described above. I understand that I may revoke this authorization at any time, to end further use and disclosure of my information, except to the extent that my information has been used or disclosed in reliance upon this authorization, or as permitted by law. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

Endo Advantage™
400 Holiday Drive, Third Floor
Pittsburgh, PA 15220

I am entitled to a copy of this authorization. The authorization expires 5 years from the date signed below.

I hereby certify the accuracy of the information submitted on, and in connection with, this application. I also acknowledge that Endo Pharmaceuticals Inc. has the right to verify my eligibility for the Endo Advantage™ Patient Assistance Program, to audit reported financial and insurance information and medical records, to contact me directly to confirm receipt of XIAFLEX®, and to revise, change, or terminate this program at any time.

Patient Signature _____ Date

Endo Pharmaceuticals Inc. reserves the right to make an independent determination of financial and medical eligibility.

Please click here for full Prescribing Information, including Boxed Warning and Medication Guide.

XIAFLEX®
collagenase clostridium histolyticum

endo pharmaceuticals
an endo international company

Rx Only

MM-05351/February 2019 www.xiaflex.com 1-800-462-ENDO (3636)