Patient Assistance Program Application

Toll Free: 1-877-VERRICA (1-877-837-7422)
Monday – Friday: 8 am to 8 pm, ET
www.Y-AccessSupport.com

Fax this form to: 1-833-837-7422 Or mail this form to: Y-Access Support Solutions
PO Box 30226 Bethesda, MD 20824

Eligibility Requirements

- ❑ You must be a legal U.S. resident and have been prescribed YCANTH™ (cantharidin) topical solution 0.7% by a licensed healthcare provider in the U.S. for treatment within the next 12 months
- ❑ You must have no insurance coverage or, if you have insurance coverage, you have been denied coverage for YCANTH
- ❑ You cannot have or qualify for federal, state or private insurance reimbursement for YCANTH
- ❑ You must meet income requirements

How to Apply

- ❑ Please verify your Medical Provider has completed a Y-Access Patient Enrollment Form and submitted to Y-Access Support Solutions. The form is available at www.YAccessSupport.com
- ❑ Please complete the application in its entirety
- ❑ Please sign the Patient Certification and Authorization section
- ❑ Please include copies of the following supporting documentation
  - Proof of legal U.S. residency
  - Copies of W2 statements for all earners in your household
  - If you don't have W2 statements, please include other proof of yearly household income such as pay stubs, disability or unemployment award letter
  - If you have prescription drug insurance, a copy of the front and back of your prescription drug card
- ❑ Mail or fax the application together with the supporting documents to the address or fax number listed above

Patient Information *The patient or his/her legal representative must complete this section*

First Name: MI: Last Name:

Date of Birth: / /

If applicable, full Name of Legal Guardian:

If applicable, full name of personal representative and a description of authority (e.g. Power of Attorney):

Address: Apartment/Suite #:

City: State: Zip Code:

Home Phone: Cell Phone:

How many people live in your household? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8+

Are you a legal resident of the U.S.? ❑ Yes ❑ No

Total annual household income of all earners (Including SSI, pension income, etc.) $

Do you have private medical insurance? ❑ Yes ❑ No

Do you have government medical insurance? (Such as: Medicare B/D, Medicaid, Veteran's Administration, State or other government-sponsored program) ❑ Yes ❑ No

Insurance company name:

Member ID#: Group #: Insurance Phone:

Please read *Patient Certification and Authorization* and provide your signature on next page

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Patient Certification and Authorization to Share Health Information

I certify: (1) the information on this form is correct and complete including all copies of documents proving my income; (2) the product(s) provided under this patient assistance program will not be sold or traded; (3) I will notify Y-Access Support Solutions ("Program") within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program, which includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D; (4) I do not have the financial resources to afford the products in the Program; (5) I will not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Program to any person or entity, including Medicare Part B or D, for reimbursement and I will not seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine I receive under this Program; (6) I have read, understand, and agree to comply with the Terms and Conditions of the Program.

I authorize the following communications: (1) I authorize Y-Access Support Solutions to contact me to request my assistance with analysis related to the quality and effectiveness of the Program; (2) when signing this application, I am agreeing to allow the manufacturer or its agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf; and (3) the Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers, or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

I understand that Y-Access Support Solutions, Verrica **and the vendors associated with administrating the Program (collectively the "Program Administrators")**: (1) reserve the right without notice to change the application form, change the Program or Program criteria, or terminate my enrollment at any time, without notice; and (2) may request and obtain information about my or my family's income.

Patient Authorization To Use and Disclose Protected Health Information: By signing below, I hereby authorize: my doctor(s), pharmacy(ies) and other healthcare providers, and my health plan or insurers ("Entities") to disclose to and share with Y-Access Support Solutions, the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees ("Y-Access Support Solutions Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, health insurance and benefits, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record to access, obtain, use, disclose, receive,
and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program or other patient assistance resources and enrolling me in such programs, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described herein and to run the Program, including internal business purposes of Verrica.

In addition, by signing below, I understand and agree that: (1) I may refuse to sign this form; (2) this authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program; (3) I understand that my doctor(s), pharmacy and other healthcare providers, and my health plan or insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization; (4) Health Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA); (5) the information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests; (6) I may revoke my authorization at any time by mailing a written withdrawal to Y-Access Support Solutions at PO Box 30226 Bethesda, MD 20824, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization; (7) this authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law; and (8) I have a right to receive a copy of this authorization.

Patient or Legal Guardian's Signature: _____ **Date:** _____