Thank you for your interest in the Shire Cares Patient Assistance & Support Program. If you are having trouble affording your Shire medicines, this program may be right for you.

The type of assistance available varies based on the medicine that has been prescribed for you, your household income, and your insurance status. To receive prescription medicine assistance from Shire Cares, you and your doctor must complete and submit this application form in its entirety, and meet program eligibility requirements. We have included a checklist at the bottom of this page to guide you through completing and submitting your application.

If you have any questions, please call the program at 1-888-CARES-55 (1-888-227-3755). We are available to answer your calls Monday through Friday, from 8 AM to 8 PM Eastern Time, except for Holidays.

Please note: Submission of a complete application form does not guarantee enrollment in Shire Cares. Each application will be considered on a case-by-case basis. For your convenience, the general income guidelines for free assistance with your Shire medicines are included below.

<table>
<thead>
<tr>
<th>Number of People in Your Household</th>
<th>Total Yearly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 person</td>
<td>$62,450</td>
</tr>
<tr>
<td>2 people</td>
<td>$84,550</td>
</tr>
<tr>
<td>3 people</td>
<td>$106,650</td>
</tr>
<tr>
<td>4 people</td>
<td>$128,750</td>
</tr>
<tr>
<td>5 people</td>
<td>$150,850</td>
</tr>
</tbody>
</table>

APPLICATION CHECKLIST: Please ensure all items on the list are completed and attached, or the application may be delayed

DOCTOR
- Complete all fields in Section 1
- Fill out prescription information in Section 2
- Indicate medicine shipping preference in Section 2
- Sign and date the application form (no stamps; only original signatures accepted, must be dated to be a valid prescription)

PATIENT
- Fill out your personal information in Section 3
- Fill out your financial information in Section 4
- Attach proof(s) of income for your household
- If you have health insurance: fill out your insurance information in Section 5 and attach a copy of your insurance card
- Provide Test Claim as advised in Section 5 (Test Claim requirements provided to the right)
- Complete Section 6

PATIENT INSURANCE INFORMATION-SECTION 5

TEST CLAIM REQUIREMENTS
- Patient’s first and last name
- Date of birth or patient’s address
- Date of claim (within the past 30 days)
- Dispensed for a quantity of 30-days
- Must show the pharmacy name and address, if the pharmacy does a screenshot that does not show the pharmacy name or address, then the pharmacist can write those two items on the test claim but they have to sign and date it

One of the following must be on the Test Claim to prove high co-pay
- Prior Authorization (PA) needed
- NDC not covered
- Not on formulary
- Co-pay amount reflects $50 or more

Please keep a copy of the application for your records

When you and your doctor have both completed the checklist above, send your form and attachments to us by fax or mail. Incomplete or incorrect information may delay the processing of your application, so please ensure that all information is provided correctly and that all signatures are obtained.

Fax: 1-877-9-CARES-9 (1-877-922-7379)
Mail: Shire Cares Patient Assistance & Support Program
P.O. Box 5666
Louisville, Kentucky 40255-0666

The documents may contain confidential information. This information is intended only for the use of the individual or entity named above. If you have received this information in error, please notify the sender at 1-877-922-7379 or by calling 1-888-227-3755.

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SECTION 1: PHYSICIAN INFORMATION

Physician Name ____________________________________________________________________________________________  *DEA# ____________________________________________________________________________________________

National Provider ID ____________________________________________________________________________________________

Facility Name ____________________________________________________________________________________________  Tax ID ____________________________________________________________________________________________

Address (No PO Box) ____________________________________________________________________________________________  City __________  State __________  Zip ____________________________________________________________________________________________

Phone __________  Ext __________  Secure Fax ____________________________________________________________________________________________

Clinic Contact ____________________________________________________________________________________________  Contact Title ____________________________________________________________________________________________

*DEA Identification number required only if prescribing a controlled substance

SECTION 2: TO BE COMPLETED BY PHYSICIAN ONLY

Patient Name ____________________________________________________________________________________________  Patient Date of Birth ____________________________________________________________________________________________

Allergies ____________________________________________________________________________________________  Current Medications ____________________________________________________________________________________________

Product (Please select)  Dosage & Administration  Distribution

☐ Vyvanse® (lisdexamfetamine dimesylate) Capsules CII  Pharmacy pick up physician must provide a prescription  ☑ Pharmacy Card
☐ Vyvanse® (lisdexamfetamine dimesylate) Chewable Tablets CII  Pharmacy pick up physician must provide a prescription  ☑ Pharmacy Card
☐ Mydayis® (mixed salts of a single-entity amphetamine product) Extended-Release Capsules CII  Pharmacy pick up physician must provide a prescription  ☑ Pharmacy Card

Please Note: Coverage will not exceed the maximum daily dosage as indicated within Vyvanse and Mydayis prescribing information. Approval for up to 12 months.

Product (Please select and complete ship product to below)  Dosage  Administration  Distribution  Refills (please select)

☐ Carbatrol® (carbamazepine) Extended-Release Capsules  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ FOSRENOL® (lanthanum carbonate) Chewable Tablets  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ FOSRENOL® (lanthanum carbonate) Oral Powder  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ Lialda® (mesalamine) Delayed-Release Tablets  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ Motegrity™ (prucalopride) Tablets  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ PENTASA® (mesalamine) Controlled-Release Capsules  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ INTUNIV® (guanfacine) Extended-Release Tablets  ☐ ______ mg  __________________________  ☑ 90-day supply  01  02  03
☐ Xiidra® (lifitegrast ophthalmic solution) 5%  __________________________  ☑ 90-day supply  01  02  03

SHIP PRODUCT TO ☐ Physician’s Office ☐ Patient’s Address (If no selection is made, product will be shipped to Patient’s Address)

Physician / Prescriber Attestation

I represent that the information above is complete and accurate. I certify that this prescription is medically indicated for this patient and that I will be supervising this patient’s treatments. I verify that to the best of my knowledge, this patient meets one of the following criteria: (1) has no health care insurance and is ineligible for public or private insurance reimbursement, and has insufficient financial resources to pay for the product prescribed, or (2) has health insurance with inadequate prescription coverage for the product prescribed, including all public programs, and the patient has insufficient financial resources to pay for the prescribed medication. I understand that Shire reserves the right to modify or terminate this program at any time. Furthermore, my signature certifies that these goods will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I understand that Shire reserves the right to recall the product, if necessary.

Original Signature of Licensed Practitioner (no stamps accepted) ___________________________________________ Date __________________

Questions? Call a Shire Cares Counselor at 1-888-CARES-55 (1-888-227-3755)
SECTION 3: PATIENT PERSONAL INFORMATION

Patient Name __________________________________________________________________________ Date of Birth __________________________________________________________________________

Phone __________________________________________________________________________________ Gender ☐ Male ☐ Female

Social Security Number __________________________________________________________________________ US Citizen / Legal Resident? ☐ Yes ☐ No

Address (No PO Box) __________________________________________________________________________

City ___________________________________________________________________________________ State __________ Zip __________

Contact Name (if other than patient) __________________________________________________________________________ Relationship to Patient __________________________________________________________________________

May we share patient protected health information with your designated contact person? ☐ Yes ☐ No

Patient Protected Health Information consists of individually identifiable health information. This includes patient demographic information, or could possibly identify the patient relating to the provision of care; and/or relates to the past, present, or future physical or mental health/condition or payment concerning a patient.

SECTION 4: PATIENT FINANCIAL INFORMATION

Number of people in your household Adults = _______ Children (18 and under within the same household) = _______

Total combined adjusted net income for all people in your household, including all household dependents $ __________ Annually

You must provide proof of income to apply for this program. Please provide a copy of your most recent:

☐ Federal Tax Return or ☐ Pay Stubs (full month’s worth of recent pay stubs) or ☐ Social Security Awards Letter

Have you lost your job in the past three (3) months? ☐ Yes ☐ No → If Yes, please attach proof of job termination or unemployment.

SECTION 5: PATIENT INSURANCE INFORMATION

Is your prescription drug copay over $50 and/or your total prescription drug deductible over $1,000? ☐ No → If Yes, please provide proof showing your prescription copay by submitting a test claim. Test claim requirements can be located under the application checklist on the first page of this application.

What type of insurance coverage do you have? (Check all that apply)

☐ None ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid

☐ State Pharmacy ☐ Employer ☐ Other __________________________ (Please fill in Name of Insurer)

For each policy you have, please attach a copy of both sides of your insurance card and fill in the following:

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Plan</td>
<td>Insurance Plan</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Name of Policy Holder</td>
<td>Name of Policy Holder</td>
</tr>
<tr>
<td>Policy Holder Date of Birth</td>
<td>Policy Holder Date of Birth</td>
</tr>
<tr>
<td>Policy ID</td>
<td>Policy ID</td>
</tr>
<tr>
<td>Group Number</td>
<td>Group Number</td>
</tr>
<tr>
<td>Plan Type</td>
<td>Plan Type</td>
</tr>
</tbody>
</table>

Has your insurance plan denied coverage for this medicine? ☐ Yes ☐ No → If Yes, proof of the denial is required. Please provide with this application.

Are you a Veteran? ☐ Yes ☐ No → If Yes, have you applied for VA benefits? ☐ Yes ☐ No
SECTION 6: PATIENT CERTIFICATION AND AUTHORIZATION

I hereby certify that I will notify Shire Cares if my financial circumstances or insurance coverage change within thirty (30) days of such change occurring. I certify that the information provided in this application is complete and accurate. I verify that the information provided in this application is complete and accurate. I further verify that I meet one of the following criteria: (1) I have no health care insurance and I am ineligible for public or private insurance reimbursement, and have insufficient financial resources to pay for the product prescribed, or (2) I have health insurance with inadequate prescription coverage for the product prescribed, including all public programs, and I have insufficient financial resources to pay for the prescribed medication. I understand that Shire Pharmaceuticals LLC reserves the right at any time and without notice to modify the application or modify or discontinue this program and related eligibility criteria.

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other health care provider to disclose to Shire Pharmaceuticals LLC and its agents all medical records and information, financial and insurance records and information as well as other identifying information, for the purpose of my participation in the Shire Cares Patient Assistance Program or for the purposes of gathering information on side effects or other safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC and its agents to contact my hospital, physician or other health care provider to obtain follow-up information on any such side effects or safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC and its agents to disclose all such records and information to any persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I authorize Shire Pharmaceuticals LLC to use my Social Security Number for identification purposes and record keeping only.

I authorize my healthcare providers, my dialysis clinic, and my health plan or insurers to give my medical and financial information to RxCrossroads, which administers the PAP on behalf of Shire Cares North America, the distributor of the medicines, and to Experian Search America, which assesses my income and ability to pay. I authorize RxCrossroads and Experian Search America to review my medical and financial information and to use it only to determine if I am eligible to participate in the PAP, to operate the PAP, or as otherwise required or permitted by law. I understand and agree that RxCrossroads and Experian Search America may contact me directly to verify the information I have submitted or to ask for additional information or documentation to process my application.

I understand that once RxCrossroads receives and processes my cancellation, I can no longer participate in the PAP and that RxCrossroads, Experian Search America and Shire Cares North America will not use my medical and financial information going forward.

Patient Name (Print) ____________________________________________________________

Patient Signature ___________________________________________ Date ______________________

If patient cannot sign or is <18 years of age, patient’s representative must sign below

Patient Representative Name & Relationship to Patient (including description of authority to make medical decisions for patient)

________________________________________________________

Patient Representative Signature _____________________________ Date ______________________

**Please note, a valid signature requires both a signature and current date.**