Arestin®
minocycline HCl 1mg
MICROSPHERES

PRESCRIPTION FORM Fax: 855-630-9783 Phone: 855-684-7481 Today's Date (mm/dd/yyyy) / /

1 PATIENT INFORMATION

Name (first, last) | Patient Gender Female ☐ Male ☐

Address | City | State | Zip

Patient Date of birth | Primary Phone # | Alt. Phone #

Primary Language (check one) English ☐ Spanish ☐ Other ☐ | Drug Allergies

2 PRESCRIBER INFORMATION

Prescriber Name | Office Email | Office Contact

Practice Name | Primary Phone # | Fax # | Preferred method of communication Phone ☐ Fax ☐

Prescriber NPI # | Delivery Address | City | State | Zip

3 PRESCRIPTION BENEFIT INSURANCE

Prescription Insurance | Drug Card ID # | Insured Name

Group # | BIN # | Rx PCN # | Plan Phone #

4 PRIMARY MEDICAL INSURANCE

Medical Insurance | Policy # | Insured Name | Group #

Plan Phone # | ☐ **CHECK HERE** to provide patient quote to purchase medication directly from the pharmacy in the event the patient's plan does not cover the medication

5 PATIENT AUTHORIZATION & COPAY ASSISTANCE PROGRAM ELIGIBILITY ATTESTATION

PATIENT AUTHORIZATION: Patient should read this Patient Authorization and sign below. I authorize my healthcare providers and health plans to disclose my protected health information such as records and my medical treatment and medications ("PHI") to CareMetx, LLC to use and disclose my PHI to: (1) determine my eligibility for benefits through the ARESTIN Rx Access® program, including copay assistance; (2) communicate with my health care providers and me about my medical care; (3) provide support services including facilitating the provision of product to me, verifying reimbursement and assisting with insurance coverage; and (4) allow authorized representatives of Bausch Health US, LLC who are under a duty of confidentiality to audit and improve the ARESTIN Rx Access program. I understand that my pharmacy, health insurers, or third-party vendors may receive payment from Bausch Health US, LLC for the services described above. I understand that once my PHI has been disclosed as described above, federal privacy laws may no longer restrict its further disclosure. CareMetx agrees to use and disclose my PHI only for the above purposes and as permitted by law. I also understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying CareMetx in writing and faxing the cancellation to: 855-630-9783 or mailing it to CareMetx, LLC, 610 Crescent Executive Ct., Suite 200, Lake Mary, FL 32746. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date I sign it, unless state law mandates a shorter period.

Patient signature _____ **Date (mm/dd/yyyy)** _____

COPAY ASSISTANCE PROGRAM ELIGIBILTY TERMS AND CONDITIONS: Eligibility Restrictions and Requirements. See full Terms and Conditions on the back of this form.* The ARESTIN Rx Access Copay Assistance Program is available for US residents only. All prescriptions must be dispensed from a pharmacy qualified by ARESTIN Rx Access. The copay assistance program is not valid for prescriptions eligible to be reimbursed, in whole or in part, by Medicare, Medicaid, Tricare, or any other federal- or state-funded healthcare benefit program, or by private plans or other health or pharmacy benefit programs which reimburse the patient for the entire cost of the prescription drugs. The maximum copay coverage is $1,500. ARESTIN Rx Access does not represent prescription drug coverage or insurance and is not intended to substitute for such coverage. Bausch Health reserves the right to rescind, revoke, terminate, or amend this offer at any time, without notice. This offer is not valid for any person that is 65 years of age or older without commercial insurance. You must be 18 years of age or older to redeem this offer for yourself or a minor.

By signing below, you are indicating that you meet the eligibility criteria and agree to the terms and conditions outlined above, as well as attesting Accredo Health Group, Inc, has your consent to fill the prescription and ship the medication directly to your prescriber's office on your behalf as the patient. For questions call: 1-855-684-7481.

Patient signature _____ **Patient date of birth (mm/dd/yyyy)** _____ **Prescriber Name** _____

6 PRESCRIPTION & PRESCRIBER CONSENT

The dental practitioner prescribing ARESTIN will determine the appropriate course of therapy for the patient. Each prescription is a 30-day supply with no refills; a new prescription is required for each order. The prescription is for the patient listed on the prescription form and cannot be resold or used for any other patient.

Complete the following prescription prior to faxing. The quantity dispensed represents no greater than a 30-day supply. New York Prescribers may attach an official NY prescription.

ARESTIN® (minocycline hydrochloride) Microspheres, 1mg Cartridges **SIG: For administration by the dental practitioner into the periodontal pocket only for the treatment of adult periodontitis**

Quantity: _____ cartridge(s) (1 cartridge per site diagnosed)

My signature indicates my (1) authorization for CareMetx, LLC ("Business Associate" or "BA"), as the operator of the ARESTIN Rx Access program, to act on my behalf for the limited purposes of transmitting this prescription by any means allowed under applicable law to the appropriate pharmacy designated by the patient's benefit plan. This may include obtaining, use and disclosure of protected health information as defined in 45 CFR 160.103 ("PHI") about my patients, to and from (i) patient's insurer, including eligibility and other benefit information, for my payment and/or healthcare operation purposes and (ii) healthcare providers, such as specialty pharmacies ("SPs"), for treatment purposes, including to forward the prescription and associated PHI to a valid SP and to track the status of medications dispensed by SPs for my patients for coordination of care and related purposes and (2) certification that I have received all necessary permission from such patients and other parties to permit the disclosure and use of their patient's PHI as described in this paragraph. BA may use PHI if necessary, for the proper management and administration of BA or to carry out the legal responsibilities of BA. BA may de-identify, use, and disclose PHI of my patients to the extent allowed by 45 CFR 164.504, provided that the de-identification complies with the requirements of 45 CFR 164.514(b). BA shall maintain administrative, technical, and physical safeguards to ensure the availability, integrity and confidentiality of PHI and shall notify me of any impermissible use or disclosure Security Incident and Breach of Unsecured PHI as required by law. This agreement incorporates and BA agrees to comply with requirements of 45 CFR 164.504 and 164.314(a)(2). This BA agreement shall terminate upon any material violation of this agreement by BA, upon the written request of physician, or two years after the signature date below. Upon termination, BA shall destroy PHI in its possession.

PRESCRIBER CONSENT: My signature below indicates I received authorization from my patient to act as his/her agent for disclosure and use of PHI as noted above and for the delivery receipt, storage, and administration of his/her ARESTIN prescription medication.

Prescriber signature (DO NOT STAMP) Dispense as written | **Prescriber signature (DO NOT STAMP) Substitution permissible** | **Date (mm/dd/yyyy)**