heart tomorrow

PROGRAM APPLICATION

PATIENT INFORMATION

Patient Name	Date of Birth	
Patient Address		
City	State	Zip
Patient Phone #	Patient Email	
Do you have any government insurance coverage for prescriptions, including without limitation Medicare, Medicaid, the Department of Veterans Affairs healthcare program, TRICARE, and any Federal or state employee benefit program?		Yes ☐ No ☐
Are you a resident of the fifty U.S. States, the District of Columbia, Puerto Rico, or the U.S. Virgin Islands?		Yes ☐ No ☐

AUTHORIZATION FOR PROGRAM PARTICIPATION AND DISCLOSURE OF PATIENT INFORMATION I understand that the Program offering is contingent upon my ability to meet the eligibility criteria for the HeartTomorrow Elective Egg Freezing Program PROGRAM ("Program") as determined by Ferring Pharmaceuticals Inc. ("Ferring") or third parties contracted by Ferring. I agree that Ferring does not have any obligation of any offering under this Program to me and I waive any and all liability of Ferring under this Program. I understand that by completing this form, I am not guaranteed eligibility to receive Program Price. In the event I am eligible for the Program, I acknowledge that this Program expires on December 31, 2024. I also understand that the Program may be changed or discontinued at any time without any notice to me and at such time the Program offerings will no longer be provided. I certify that I am paying cash for the MENOPUR prescribed as part of this Program and am not enrolled in any Federal or state health care program, including without limitation Medicare, Medicaid, the Department of Veterans Affairs healthcare program, TRICARE, and any Federal or state employee benefit program. I agree that I will report any assistance I may receive through the Program to my insurance company as may be required by my benefit agreement. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the Program if my insurance status changes.

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me to disclose any information regarding my health, treatment, and coverage that pertains to his application for the Program to Ferring Pharmaceuticals Inc. its affiliates, or contracted third parties for the following purposes: (i) to determine eligibility for the Program, (ii) to administer, evaluate, and maintain the high quality of the Program; and (iii) for Ferring's internal business purposes, including quality control and research. I understand that once the Program receives my health information, it may communicate with my health care providers and insurers to determine Program eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program (should I qualify). I understand that I may cancel this authorization at any time by writing to the Program as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in the Program. Once the Program receives and processes my cancellation request, the Program will not use my health information going forward. I understand that cancelling the Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 3 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the Program and will no longer be protected by HIPAA.

Patient Authorization:	Date:

FERRING PHARMACEUTICALS

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PROGRAM APPLICATION

PRESCRIBER INFORMATION

Prescriber's Name	Office Name		
Prescriber's Address			
City	State	Zip	
Office Phone #	Office Fax #		
Office Contact Name			☐ ☐
State License #	State where licensed:	NPI#:	☐ ☐

PHARMACY MEDICATIONS

MENOPUR

☐ MENOPUR (menotropins for injection)

Quantity:

Pharmacy:

I certify that the information provided in this application is complete and accurate to the best of my knowledge. I certify that the above-named patient will be undergoing an elective egg freezing cycle under my care for fertility preservation "using MENOPUR and will be prescribed a minimum of 20 vials of MENOPUR at the initiation of her cycle. I understand eligibility under this program is subject to the Program's approval and the patient's continuing compliance will all eligibility requirements, as set by Ferring. I agree to allow Ferring or its authorized agent(s) to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the Program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient to Ferring and authorized third parties designated by Ferring.

Prescriber Signature:	Date:

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MEDICATION PROGRAM

The HeartTomorrow Program offers MENOPUR for $68/vial (the "Price") for eligible cash paying patients who are undergoing a controlled ovarian stimulation ("COS") elective egg freezing cycle. The Price is contingent upon a minimal initial prescription fill of 20 vials of MENOPUR. Please see Terms and Conditions below.

Eligible patients are cash-paying U.S residents who satisfy the terms and conditions below:

Terms and Conditions:

- Patient must be 18 years of age or older;
- Patient must be a resident of the United States or U.S. Territories;
- Patient must be an elective/social egg freezing patient
- This excludes patients that are undergoing any other type of COS cycle
- Frozen embryo cycles are not eligible
- The initial fill to activate coupon MUST be for a minimum of 20 vials of MENOPUR.
- The coupon will expire 30 days from date of initial fill/activation.
- Patient must be paying cash for their medications
- The prescription must be filled at a HEART participating pharmacy with Ferring's network, www.ferringfertility.com
- Patients participating in any Federal or state health care program, including without limitation Medicare, Medicaid, the Department of Veterans Affairs healthcare program, TRICARE, and any Federal or state employee benefit program are not eligible for the Program.
- Patient must notify the Program if their insurance status changes.
- Patient must not seek reimbursement from their insurance plan for their out-of-pocket costs for MENOPUR
- All required forms must be completed accurately and submitted with supporting documentation to determine program eligibility.
- Void if prohibited by law or restricted. The selling, purchasing, trading, or counterfeiting of this offer is prohibited by law.
- This Program is not health insurance.
- Offer may not be combined with any other discount, coupon, or other offer for MENOPUR
- No other purchase necessary.
- Offer expires December 31, 2024.
- Ferring Pharmaceuticals reserves the right to rescind, revoke, or amend this offer at any time without notice.
- When you use this offer, you are certifying that you understand the program rules, regulations, and terms and conditions, and that you will comply with them.

Checklist for submitting an application:

- Ensure all sections of the application are completed. Please make a copy before sending as no documents will be returned.
- Patient's signature and date are required on the application.
- Prescriber's signature and date are required on the application. Stamps are NOT acceptable.
- Pharmacy must be identified for issuance of coupon to receive Program Price
- Email completed application and documentation to hearttomorrow@envisionrx.com

Upon receipt of a completed application, the patient will be notified of program eligibility by e-mail or mail. If the patient is eligible for the Program, a coupon will be issued to identified pharmacy for use once a prescription is received for the minimum of 20 vials of MENOPUR to received discounted pricing.

Please contact HeartTomorrow@envisionrx.com with any questions or for additional assistance. Someone can be reached at this email Monday-Friday 9am-5pm EST.

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