Tarsus Connect™
Patient Assistance Program

Phone: 1-866-846-3092 | Fax: 1-866-901-1534
P.O Box: 220645, Charlotte, NC 28222
Monday-Friday 9am to 7pm Eastern Time Zone

Application for Free Tarsus Medicine

To be eligible, a patient must:

- Reside in the United States or a U.S. Territory (citizenship is not required)
- Have limited or no prescription insurance coverage
- Meet income guidelines for the medication for which the patient is seeking assistance
- Have a valid on-label prescription for XDEMVY™ (lotilaner ophthalmic solution) 0.25%
- Be treated by a licensed U.S. healthcare provider
- Be 18 years of age or older

Patient Instuctions

☐ Check eligibility criteria above to see if you may be eligible for the program.
☐ Check your application on pages 2-4 and make sure all the blanks are filled in or mark N/A.
☐ Include copies of the front and back of ALL your insurance cards.
  - If you have any Medicare plan, please provide your traditional Medicare Red/White/Blue card along with all other Part D or Advantage plan ID cards

☐ Read the Patient Authorization and Attestation on pages 3-4.
  - Patient Authorization describes what data the Tarsus Connect Patient Assistance Program collects and how it will be used. We can't enroll you in the program without some medical information from your doctor. You need to give your doctor permission to share that information with the Tarsus Connect Patient Assistance Program

☐ Sign and date Section 6 on page 4
  - Your signature is not required for treatment by your doctors, but it is required if you want to participate in the Tarsus Connect Patient Assistance Program. We need it to process your application

Prescriber Instuctions

☐ Complete and fax the Prescriber and Prescription Information on pages 5-6.
  - Make sure to sign and date the Prescription section on page 5

☐ For insured patients, manage any required prior authorization (PA).
  - Include all PA and appeal results with the submitted Prescriber Application

☐ Read the healthcare provider attestation, sign and date Section 4 on page 6.
☐ For XDEMVY refills, please submit a Tarsus Connect Patient Assistance Program Refill Request form to this program.

Applications MUST be filled out completely and accurately.
Any missing information will result in a processing delay or application denial.

Fax or mail your completed application to:
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Mail: P.O Box: 220645, Charlotte, NC 28222

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Patient Application

SECTION 1: Patient Information

Patient First Name _____ Last Name _____
Date of Birth (mm/dd/yy) _____ Gender ☐ Male ☐ Female
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Phone _____ Phone type? ☐ Mobile ☐ Home
Email _____
Preferred Language ☐ English ☐ Spanish ☐ Other _____
Communication Preference? ☐ Phone Call ☐ Email ☐ Postal Mail

SECTION 2: Alternative Contact *(able to act on behalf of Patient for Program actions except authorization)*

Alternative Contact
First Name _____ Last Name _____
Phone _____ Phone type? ☐ Mobile ☐ Home
Relation to Patient _____

SECTION 3: Income Information

Annual Gross Household Income $____,____ Household size (including patient) _____

☐ I authorize Tarsus Connect and their agents to use my demographic information and other information provided to obtain and assess my credit report and information derived from public record and other sources to estimate my income in conjunction with the eligibility determination process, including Real Time Income Projections (RTIPs).

SECTION 4: Insurance Information - submit copies of the front and back of ALL insurance cards and write details of your insurance cards below:

Do you have insurance for prescription drug coverage? ☐ Yes ☐ No (skip to section 5)

Plan Type	Plan Name	ID #	Phone #
Medicare (Red/White/Blue card)			
Medicare Part D/Advantage			
Medicaid/Tricare/VA/DoD			
Private Insurance			

If you have insurance through an employer – Employer Name _____

SECTION 5: Patient Authorization and Attestation - Which best describes you?

☐ **Patient** (skip to page 3) ☐ **Legally Authorized Representative** (complete information below)

Legally Authorized
Representative First Name _____ Last Name _____
Relation to Patient _____ Date of Birth (mm/dd/yy) _____
Phone _____ Phone type? ☐ Mobile ☐ Home
Email _____

HIPAA Authorization

By signing this authorization, I authorize my health plans, physicians, long-term care and other healthcare providers, pharmacies, and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to use and disclose my Protected Health Information ("PHI"), which is defined to mean all information regarding my health care, including but not limited to, my name, address and phone number, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to Tarsus Pharmaceuticals and its representatives or agents (collectively "Tarsus"). I authorize and direct my Providers to use my PHI to make disclosures of PHI to Tarsus for the following purposes:

- Reimbursement support associated with the filling of my prescription for XDEMVY™ (lotilaner ophthalmic solution) 0.25%, including the performance of an insurance verification and assisting in securing of any insurance coverage for XDEMVY to which I am entitled.
- Facilitating the provision of patient assistance, reduced cost medication and/or other XDEMVY-related services offered by Tarsus.
- Receiving marketing and promotional communications related to my disease condition, XDEMVY, and other information from Tarsus via the contact information I have provided.

With respect to any disclosures by my pharmacies, I understand that my pharmacies will receive remuneration (payment) from Tarsus for making disclosures of PHI and/or support services to Tarsus.

I understand that once my PHI is disclosed under this authorization, it is no longer protected by Federal privacy laws, including HIPAA, and may be further disclosed by Tarsus.

I understand that I may refuse to sign this authorization and that treatment, payment, or eligibility for benefits is not conditioned on my signing this authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Tarsus Connect Patient Assistance Program (should I qualify).

I understand that this authorization is valid for a period of 10 years or for a shorter period dictated by applicable state law.

I understand that I may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to Tarsus Connect at P.O Box: 220645, Charlotte, NC 28222, but that this cancellation will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my Providers.

Patient Attestation:

I verify that I meet the eligibility requirements and that the information provided on this application is complete and accurate. I agree that I will notify Tarsus if my financial information or insurance coverage changes. I certify that no part of the cost of XDEMVY is or will be covered or reimbursed by a federal or state healthcare program, including but not limited to Medicaid and Medicare. I agree that I will not submit any claims to insurance for reimbursement for my prescriptions covered under the Patient Assistance Program. I understand and agree that any assistance I receive under the Patient Assistance Program will not count towards my true-out-of-pocket costs (TrOOP) as defined under the Medicare Modernization Act.

I understand that the Tarsus Connect Patient Assistance Program may request documentation to verify financial or insurance information and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that Tarsus reserves the right at any time and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the Tarsus Connect Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

SECTION 6: Patient Authorization and Attestation/Certification and Signature

I have read and agree to the Tarsus Connect Patient Assistance Program Patient HIPAA Authorization

Signature of Patient/Legally Authorized Representative (Required)

_____

Today's Date (Required) ___/___/_____

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Prescriber and Prescription Information

SECTION 1: Prescriber Information

Prescriber First Name _____ Last Name _____

Prescriber NPI _____

Office Address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Office Contact Information

Office Contact

First Name _____ Last Name _____

Phone _____ Extension _____

Email _____

SECTION 2: Prescription

Patient First Name _____ Last Name _____

Date of Birth (mm/dd/yy) _____ Gender ☐ Male ☐ Female

Allergies? ☐ No ☐ Yes, list _____

List Other Medications: _____

Diagnosis: _____

Product: XDEMVY (lotilaner ophthalmic solution) 0.25%

Quantity: 1 eyedrop container (42 day supply)

Directions: Instill one drop in each eye twice daily (approximately 12 hours apart) for 6 weeks

Other: _____

Prescriber Signature (Wet Signature Required) _____

Today's Date (Required) ___/___/_____

Prescribers in all states must comply with the prescription requirements of their state. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription form, in addition to this enrollment form. Prescribers may need to submit an electronic prescription to the Specialty Pharmacy.

SECTION 3: Prior Authorization Requirement

If the patient is insured and the insurance requires a prior authorization (PA), you must submit a copy of the PA outcome. When applicable, also submit a copy of PA appeal outcome.

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SECTION 4: Healthcare Provider Certification/Authorization and Signature

I certify to the following: (1) Treatment with this medicine for this patient is medically necessary, based on my independent clinical judgment; (2) Information that I provide to Tarsus Connect, and in this form, is complete and accurate; (3) I have the authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (4) To the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid,Medicare, or other public or private programs), or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication, and the patient's insurance coverage for this medication, if any, does not require his/her application to Tarsus Connect and/or does not change or hide the patient's insurance coverage to make them appear to be underinsured and eligible for Tarsus Connect. (5) I will immediately notify Tarsus Connect if I become aware that this patient's insurance or income status has changed; (6) I will not submit an insurance claim or other claim for payment to any third-party payer (private or government), and I will forego any appeal of any denial of insurance coverage, for medication provided by Tarsus Connect for this patient, nor will I count the free medicine towards this patient's true out-of pocket costs (TrOOP); (7) Any medication provided by Tarsus Connect for this patient will not be resold, nor offered for sale, trade or barter, or returned for credit. I understand that: (1) Tarsus Connect reserves the right to verify all information provided by healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment based on available resources; (2) Tarsus Connect reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) Tarsus Connect, and its agents and assignees, are relying on the certifications in this form.

I have read and agree to the Tarsus Connect Patient Assistance Program Healthcare Provider Certification/Authorization and authorize the above prescription.

Prescriber Signature (Required) _____

Today's Date (Required) ___/___/_____

Please visit www.xdemvy.com for Important Safety Information and full Prescribing Information.