neffy®
(epinephrine nasal spray)

ARS Patient Assistance Program Application

Please fax completed form from prescriber's office to #: (833) 396-0939

ARS Pharmaceuticals Operations, Inc. (ARS) provides medically necessary ***neffy*** free of charge to qualifying applicants through its Patient Assistance Program ("PAP" or "Program"). Submission of a complete application does not guarantee enrollment into the Program. Each application will be considered on a case-by-case basis.

ELIGIBILITY REQUIREMENTS

You may qualify if:
(1) You have a valid prescription for ***neffy***;
(2) You are a legal resident of the United States, Puerto Rico or the U.S. Virgin Islands;
(3) You are uninsured or, if insured, you do not have any government or commercial drug coverage[†] for ***neffy***; and
(4) You have an annual household adjusted gross income[††] of less than 350% of federal poverty level
(for federal poverty levels, visit *aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines*)

[†] Your commercial or government-funded insurance plan recently denied a coverage request (i.e. PA or appeal) for neffy.
[††] Annual household adjusted gross income is the annual gross income from all earners in the household (including wages, Social Security, Social Security disability, unemployment, pensions and other income) minus eligible adjustments to income.

*Required field

1. Patient Information – To Be Completed by Patient

*Patient Name (Last, First):		*SSN:
*Date of Birth (MM/DD/YYYY):	*Weight (lbs):	*Gender: ☐ Male ☐ Female
*Address (Cannot be a PO Box):	*City:	*State: *Zip:
*Cell Phone: ☐ Text Opt-in[‡]	Home Phone:	Other Phone:
[‡] I authorize ARS and its partners to send me text messages about my ***neffy*** prescription order. Standard message and data rates may apply. To opt out, call (877) 207-9529		
*Email Address:	If Minor, Parent/Personal Representative Name (Last, First) and Relationship:	
*Do you have prescription drug coverage? ☐ Yes ☐ No	*Do you have commercial insurance? ☐ Yes ☐ No	*Please check any of the programs you are you eligible for: ☐ Medicaid ☐ Medicare ☐ Tricare
*Number of People in Household:	*Annual Household Adjusted Gross Income (Patient/Guardian may be required to show proof of income):	
Prescription Insurance Plan Name:	Prescription Insurance Member ID:	Prescription Insurance Phone:
Rx BIN Number:	Rx PCN:	Rx Group:

Patient Declaration:

I certify that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand that any assistance in the form of free ***neffy*** (the "Product") is contingent on my ability to meet the eligibility criteria for the ***neffy*** PAP as determined by ARS Pharmaceuticals Operations, Inc. and its affiliates, agents and representatives, including its third party patient support program service provider (collectively referred to as the "Program") and that my application for assistance does not guarantee free Product will be provided. Any assistance for which I may be eligible will only be awarded after my documentation has been received and approved by the Program. In the event that I am eligible for the Program, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Program. Assistance is not guaranteed for any specific time frame and may be terminated at any time for any reason without any notice to me. There is no guarantee that assistance will be available in any subsequent year(s).

ARS PHARMA

For assistance with any questions, call (877) 207-9529 • Monday through Friday from 8AM to 7PM Eastern Standard Time
For additional information on ***neffy***, please visit our website ***neffy***.com
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Patient Declaration (continued):

I agree that I will notify the Program within thirty (30) days if my insurance or financial situation changes as this may impact my eligibility to participate in the Program. I agree that the Program and its affiliates, agents and representatives shall not be liable for any damages, of any kind, without limitation, in connection with my receiving Product assistance, benefits, or services provided by the Program. I have read, understand and agree to all of the above.

If I refuse to sign below, I acknowledge that I will not be considered for any benefits of the PAP, but this will not affect my ability to obtain medical treatment, seek payment for medical treatment, or affect my insurance coverage or eligibility.

*Patient's Signature:	*Date of Signature:
*Personal Representative Name (if applicable): *Personal Representative Signature:	*Date of Signature:

*If signed by personal representative, describe legal authority to do so:

We will contact you if additional documentation is required.

2. Patient Authorization to Use and Disclose Protected Health Information - To Be Completed by Patient

- I authorize my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to ARS Pharmaceuticals Operations, Inc. and its affiliates, contractors and agents, including their third-party patient support program service provider (collectively "ARS") for the purposes described below.
- I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) facilitating quality and adverse event reporting activities; (vi) conducting data analytics, market research and Program related business activities; (vii) contacting me by direct mail or by electronic or telephonic means via the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

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- I understand that I may cancel this Authorization at any time, by writing to ARS Pharmaceuticals Operations, Inc. Attn: Authorizations, 11682 El Camino Real, Suite 120, San Diego, CA 92130, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

*Patient's Signature:	*Date of Signature:
*Personal Representative Name (if applicable): *Personal Representative Signature:	*Date of Signature:
*If signed by personal representative, describe legal authority to do so: We will contact you if additional documentation is required.	

3. Patient Medicare Part D Enrollee Consent - To Be Completed by Patient (if applicable)

I agree that if I am approved for PAP as a Medicare Part D Enrollee, that ARS or the Program may give my Personal Information to the Centers for Medicare & Medicaid Services ("CMS") to confirm my Medicare Part D enrollment status and let CMS and my Medicare Part D plan know of this enrollment in PAP. Further, I understand that upon approval, I will receive ***neffy*** from PAP through the end of this calendar year for which my application was approved. I agree that I: (i) will not seek ***neffy*** from my Medicare Part D prescription plan while receiving ***neffy*** from PAP; (ii) will not seek or accept reimbursement for any medication dispensed by PAP from any government program or third-party insurer; (iii) will not seek credit for any PAP medication(s) toward my True-Out-of-Pocket ("TrOOP") costs; and (iv) will notify the Program within thirty (30) days if my prescription drug coverage changes in any way.

*Signature required ONLY if patient is a Medicare Part D enrollee Member Number/ID#:	
*Patient or Legal Representative Signature:	
*PAP Application Enrollment Year:	*Date:

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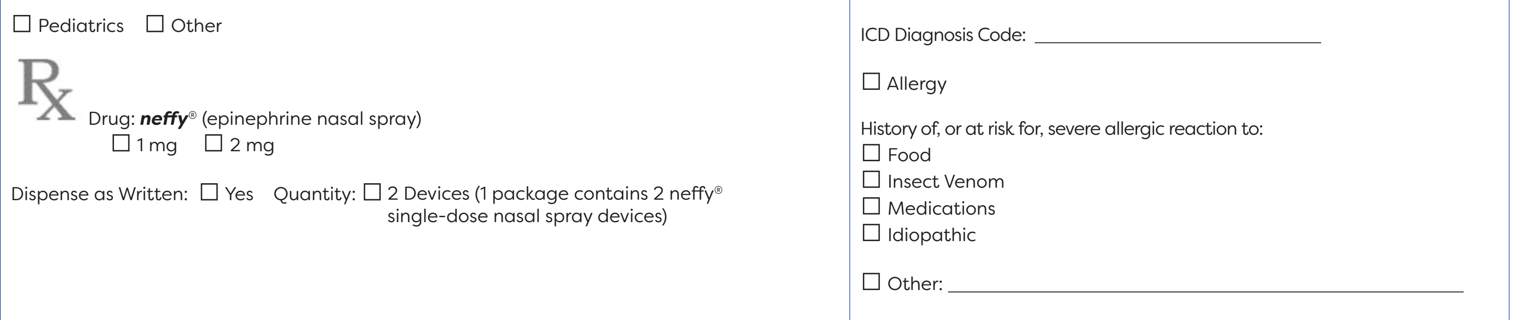
4. Prescriber and Prescription Information – To Be Completed by Prescriber

*Patient Name (Last, First):	*Patient Date of Birth (MM/DD/YYYY):	*Patient Weight (lbs):	
*Prescriber Name (Last, First):			
*Prescriber Address:	*City:	*State:	*Zip:
*Prescriber's Primary Specialty:	*NPI:	DEA:	
*Office Contact Name (Last, First):	*Office Contact Direct Phone:	*Office Fax:	



☐ Pediatrics ☐ Other

Rx

Drug: ***neffy***® (epinephrine nasal spray)
☐ 1 mg ☐ 2 mg

Dispense as Written: ☐ Yes Quantity: ☐ 2 Devices (1 package contains 2 neffy® single-dose nasal spray devices)

ICD Diagnosis Code: ______________________________

☐ Allergy

History of, or at risk for, severe allergic reaction to:
☐ Food
☐ Insect Venom
☐ Medications
☐ Idiopathic

☐ Other: ____

Instructions:
Use 1 spray in one nostril for severe allergic reaction. Use second spray in the same nostril if no improvement in 5 minutes.

Comments:

I verify that the information provided is current, complete and accurate to the best of my knowledge.
I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party, including patient. By signing this form, I authorize the Program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Program for the dispensing of ***neffy***. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

*Prescriber's Signature: Signature stamps are not acceptable.	*Date of Signature:

Please attach all prescriptions on official state prescription form if mandated by individual state laws.

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