

## PROGRAM APPLICATION

### PATIENT ELIGIBILITY CRITERIA:

Medicare Beneficiary	Commercially-Insured but Not Covered	Uninsured
<ul style="list-style-type: none"> <li>• Patient must have an FDA-approved, on-label diagnosis for TYMLOS® (abaloparatide) injection</li> <li>• Patient must have an Annual Household Income &lt;300% Federal Poverty Level (FPL)*</li> <li>• Patient must be a legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico</li> <li>• Patient must not be enrolled in Medicaid, Tricare, Veterans Health Administration, or Indian Health Service benefit programs</li> <li>• Patient must not be enrolled in full Low-Income Subsidy (LIS)<sup>†</sup> from the Social Security Administration</li> <li>• Patient must not be eligible for State Pharmacy Assistance Programs in which TYMLOS participates</li> </ul>	<ul style="list-style-type: none"> <li>• Patient must have an FDA-approved, on-label diagnosis for TYMLOS® (abaloparatide) injection</li> <li>• Patient must have an Annual Household Income &lt;300% Federal Poverty Level (FPL)*</li> <li>• Patient must be a legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico</li> <li>• Patient must not be enrolled in Medicaid, Tricare, Veterans Health Administration, or Indian Health Service benefit programs</li> <li>• Patient must have neither insurance coverage for nor access to other coverage for TYMLOS</li> </ul>	<ul style="list-style-type: none"> <li>• Patient must have an FDA-approved, on-label diagnosis for TYMLOS® (abaloparatide) injection</li> <li>• Patient must have an Annual Household Income &lt;300% Federal Poverty Level (FPL)*</li> <li>• Patient must be a legal resident of the contiguous United States, Alaska, Hawaii, or Puerto Rico</li> <li>• Patient must not be enrolled in a Medicare or commercial prescription drug plan or Medicaid, Tricare, Veterans Health Administration, or Indian Health Service benefit programs</li> </ul>

\*Find current U.S. Federal Poverty Guidelines online at [www.aspe.hhs.gov/poverty-guidelines](http://www.aspe.hhs.gov/poverty-guidelines)

<sup>†</sup>To apply for LIS, please contact the Social Security Administration at (800) 772-1213 (TTY 800-325-0778) or go to <https://secure.ssa.gov/i1020/start>

### INSTRUCTIONS:

1. Complete all fields to ensure application can be processed
2. Make sure the application is signed and dated by the prescriber
3. Make sure the application is signed and dated by the patient
4. Include all Required Documentation (see below)
5. Send completed application and required documents:  
 Fax to **1-800-910-4610** or Mail to  
**Radius Assist Patient Assistance Program (PAP)**  
**2503 E. 54th St. N.**  
**Sioux Falls, SD 57104**

### ADDITIONAL INFORMATION:

- Patients and prescribers will be notified by phone or mail of the approval or denial of the application
- Please allow up to 4 weeks for application processing
- Approved patients may receive up to a 3-month supply of medication at a time, for up to 12 months, subject to continued eligibility and pursuant to a valid prescription
- Questions? Patients and prescribers may call Radius Assist at **1-866-896-5674**

### REQUIRED DOCUMENTATION:

Patients	Prescribers
<ul style="list-style-type: none"> <li>• Sections 1 through 5 completed in their entirety (page 2)</li> <li>• Section 4 signed and dated (hard copy/wet signature required)</li> <li>• Copy of insurance card(s) and pharmacy benefits card(s) (front and back)</li> <li>• Copy of most recent proof of income (e.g., Form 1040, Form 1099, Form SSA 1099, etc.)</li> <li>• A signed and notarized Power of Attorney (POA) for signatures other than the patient's original signature</li> </ul>	<ul style="list-style-type: none"> <li>• Sections 6 and 7 completed in their entirety (page 3)</li> <li>• Section 7 signed and dated (hard copy/wet signature required)</li> <li>• For commercially-insured patients, a copy of prior authorization and appeal denial(s) must be submitted</li> </ul> <p style="text-align: center;"><b>DO NOT INCLUDE PATIENT MEDICAL RECORDS</b></p>



## 6. PRESCRIBER INFORMATION

Prescriber Name (Last):

(First):

Practice Name:

Practice Street Address:

City:

State:

Zip:

NPI Number:

Office Contact Name:

Best Phone Number to Contact You:

Fax Number:

## 7. PRESCRIPTION AND PRESCRIBER CERTIFICATION

Patient Name (Last):

(First):

Date of Birth:

Street Address:

City:

State:

Zip:

Medication Name: TYMLOS® (abaloparatide) injection 80 mcg

Directions: Daily, subcutaneous 80 mcg injection

Quantity: 4.68 mL (90 days)

Refills: 0 1 2 3 PRN

Has patient previously been on TYMLOS? Yes No

If Yes, for how many months?

Pertinent Medical History:

Concurrent Medications:

Allergies:

What is the patient's diagnosis? M80. \_\_ osteoporosis with current pathological fracture

M81. \_\_ osteoporosis without current pathological fracture

Ancillary Supplies: One-hundred pen needles (100 days) Refills: 0 1 2 3 PRN

By signing this form, I certify the following: (1) I am prescribing TYMLOS® (abaloparatide) for the patient identified on this form based on my independent clinical judgment, and that this prescription medication is medically indicated for the patient and that it will be used as directed; (2) I have authority to disclose this patient's information and I have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization; (3) my license is active and in good standing with my state medical board and I am not debarred by any local, state, or federal entities; (4) to the best of my knowledge, the patient identified on this form does not have prescription drug insurance coverage under (a) Medicaid, Tricare, Indian Health Service, or Veterans Health Administration

benefit programs, (b) if a Medicare beneficiary, has applied for and has been denied LIS from the Social Security Administration or has not applied because the patient has an annual household income >150% FPL, and is not eligible for a state pharmacy assistance program in which TYMLOS participates, and (c) if commercially insured, has neither insurance coverage for nor access to other coverage for TYMLOS® (abaloparatide); (5) I will immediately notify the Radius Assist Patient Assistance Program ("Radius Assist" or the "PAP") if I become aware that this patient's insurance or income status has changed; (6) I will be supervising the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge;

(7) I will not submit an insurance claim or any other claim for payment for any medication dispensed or administered to the patient through the PAP from insurer, health plan, or government program, including Medicare and Medicaid. I understand that: (1) Radius Assist reserves the right to verify all information provided by any healthcare professionals, suspend participation where inadequate information is provided, and limit enrollment in the PAP based on available resources; (2) Radius Assist reserves the right to modify or terminate this program, or recall or discontinue medications, at any time without notice; (3) Radius Assist, and its agents and assignees, are relying on the certifications in this form.

Original Prescriber Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

# RADIUS ASSIST™

Patient Assistance Program

