CYCLE PHARMA

Nityr™ nitisinone Tablets

Phone: 1-800-847-8714
Fax this form: 1-800-842-5163
www.nityr.us

NITYR™ PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

TO APPLY FOR ASSISTANCE

- Complete both sides of this form.
- The Patient or Guardian must sign it.
- Please Fax this form to: 1-800-842-5163 or e-mail it to pap@nityr.us including any copies of documentation requested below.
- For assistance when completing this form, please contact the NITYR™ Patient Support Program on 1-800-847-8714 (hours Monday-Friday 9 am to 5 pm EST)

PATIENT INFORMATION

Patient's name: DOB: Social Security Number (last 4 digits):

Parent/Guardian name (*if applicable*): Relation:

Sex: ☐ Female ☐ Male

Language: ☐ English ☐ Spanish ☐ Other:

Patient's Address:

Suite/Floor/Apt #: City: State: Zip:

Home Phone: Cell Phone/Other: E-mail:

ELEGIBILITY AND TREATMENT INFORMATION

Primary Diagnosis:

Residency: US resident for at least 6 months or is a US citizen: ☐ Yes ☐ No

Insurance: *(attach copy of patient's insurance cards, front and back if applicable)*

Patient is uninsured (no third-party or private insurance): ☐ Yes ☐ No

Patient is underinsured (no coverage for NITYR™ (nitisinone) tablets): ☐ Yes ☐ No *(attach copy of insurance denial/appeal)*

HEALTHCARE PROVIDER INFORMATION

Physician Name:	Physician Specialty:
Physician Tax ID:	State Licence Number:
Facility/Practice Name:	NPI Number:
Office Contact:	Facility Type:
Street Address:	Office Contact Phone:
Phone Number:	City, State, ZIP:
Product: **NITYR™ (nitisinone) tablets**	Fax Number:

PATIENT NAME: PATIENT DATE OF BIRTH:

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PATIENT INCOME INFORMATION

Please fill out the information below as it relates to the patient's ANNUAL household income:

$	Social Security Disability Income (SSDI) (Beginning /)
$	Supplemental Security Income (SSI)
$	Aid from the Department of Public Welfare
$	Unemployment Benefits (From / to /)
$	Workers Compensation Benefits (From / to /)
$	Dividends, interest, or investment accounts
$	Employment (for the entire Patient's household)
$	Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive – may include percentage of rent, food, etc.)

The Patient's ANNUAL household income currently is $. *(Please include dollar amount)*

Number of People in the Patient's Household:

PATIENT ATTESTATION

My signature attests that the information on this form is true and correct. My signature also means that I understand and agree to permit the uses and releases of my information as described above and authorize the NITYR™ Patient Support Program and its agents and assignees to use the 4 digits of my social security number for identification purposes and recordkeeping. I understand that:

- Completing this form does not guarantee that I will qualify for the PAP.
- The NITYR™ Patient Support Program and its agents may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Including, but not limited to proof of income.
- Any medicines supplied by the PAP shall not be sold, traded, bartered or transferred.
- Cycle Pharmaceuticals Ltd. reserves the right at any time and without notice to modify or discontinue the PAP and its criteria.

Patient/Guardian Signature: _____

Relationship to Patient: _____

Date:

RESET FORM