



**Nityr**<sup>TM</sup>  
nitisinone  
Tablets

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

## NITYR<sup>TM</sup> 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<sup>TM</sup> 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: <input type="checkbox"/> Female <input type="checkbox"/> Male			
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance: (attach copy of patient's insurance cards, front and back if applicable)			
Patient is uninsured (no third-party or private insurance): <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient is underinsured (no coverage for NITYR <sup>TM</sup> (nitisinone) tablets): <input type="checkbox"/> Yes <input type="checkbox"/> 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 <sup>TM</sup> (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:

\$ <input type="text"/>	Social Security Disability Income (SSDI) (Beginning <input type="text"/> / <input type="text"/> )
\$ <input type="text"/>	Supplemental Security Income (SSI)
\$ <input type="text"/>	Aid from the Department of Public Welfare
\$ <input type="text"/>	Unemployment Benefits (From <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> )
\$ <input type="text"/>	Workers Compensation Benefits (From <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> )
\$ <input type="text"/>	Dividends, interest, or investment accounts
\$ <input type="text"/>	Employment (for the entire Patient's household)
\$ <input type="text"/>	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

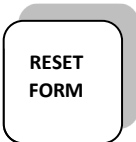
My signature attests that the information on this form is true and correct. My signature also means that I understand and agree to permit the uses and releases of my information as described above and authorize the NITYR™ Patient Support Program and its agents and assignees to use the 4 digits of my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



**Confidentiality Statement:** This facsimile is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately and call 1.800.847.8714 to obtain instructions as to the proper destruction of the transmitted material.

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