Qutenza® (capsaicin) 8% topical system

MY QUTENZA CONNECT COST SAVINGS PROGRAM PATIENT ENROLLMENT FORM

Complete this form and include a copy of your EOB and Proof of Payment for QUTENZA to apply for the My QUTENZA Connect Cost Savings Program

1. Complete the information requested below and sign this form
2. Include a copy of your EOB and Proof of Payment
3. Mail your signed form, EOB and Proof of Payment to the address to the right

NOTE: Additional documentation, such as proof of billed claims or a CMS 1500 form, may be requested.

IQVIA, Inc.
Attn: Claims Processing Dept.
430 Mountain Avenue
Suite 105
New Providence, NJ 07974

Assignment of benefits:

☐ If you paid your bill in full prior to the procedure and want the remittance check sent directly to you, **check this box and complete Section A only.** Proof of payment is required.

☐ If you did not pay your bill prior to the procedure and need the remittance payment sent directly to your provider's office, **check this box and complete Section A. NOTE: Section B must be completed by your provider.**

A. PATIENT TO COMPLETE

Fill out the patient information section and submit this form with a copy of your EOB and Proof of Payment.

First name: _____ Last name: _____

Date of birth: ____/____/____ Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: ____/____/____

☐ By signing above, you attest that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by your insurance, Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. You attest that you are not covered under Medicare, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD), or any other government (state or federally-funded) program, and you understand that you are liable for any misrepresentations herein to the full extent of applicable law. You attest that the use of QUTENZA is for an FDA-approved use, specifically diabetic nerve pain of the feet or post-shingles nerve pain. Please see page 2 for full Eligibility Criteria, Terms, and Conditions.

HEALTHCARE PROVIDER DIRECTIONS

Complete the treatment details in the section below, including the total amount(s) billed to insurance, in order to allow the patient to submit the form. By completing Section B below, you understand that payment will be remitted directly to you and not the patient.

B. PROVIDER TO COMPLETE

Provider to complete in order to remit payment directly to the provider, and not the patient.

Proof of Treatment

Medication Administration ☐ **Yes** ☐ **No** Date of QUTENZA Treatment: ____/____/____

CPT code billed: _____ Total amount billed for administration $ _____

Proof of QUTENZA

☐ **QUTENZA J7336** Total amount billed to insurance for QUTENZA $ _____ ☐ **Specialty pharmacy utilized**

Authorized office staff name: _____ Signature: _____

☐ By signing above, you attest that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by the patient's insurance, Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. You attest that the patient is not covered under Medicare, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD), or any other government (state or federally-funded) program, and you understand that you are liable for any misrepresentations herein to the full extent of applicable law. You attest that the use of QUTENZA is for an FDA-approved use, specifically diabetic nerve pain of the feet or post-shingles nerve pain. Please see page 2 for full Eligibility Criteria, Terms, and Conditions.

Administering HCP name: _____ Practice NPI #: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____ Office phone: _____

QUTENZA Savings Program is used only in conjunction with a commercial payer | Questions? Call 833-295-3579

The categories of personal information collected in this form include name, date of birth, and treatment details. The personal information collected will be used for enrollment form submission and eligibility approval for QUTENZA Savings Program and to perform research analytics on a de-identified basis. For more information about the categories of personal information collected by Averitas and the purposes for which Averitas uses personal information visit: https://www.averitaspharma.com/privacy-statement/.

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Eligibility Criteria, Terms, and Conditions:

By using this offer, you confirm that you currently meet all eligibility criteria and will comply with all terms and conditions, as described below:

1. The My QUTENZA Connect Cost Savings Program (the "Program") is available only to eligible adult patients prescribed QUTENZA for use consistent with approved indications in US product labeling for QUTENZA. Eligible patients must reside in the US, Puerto Rico, or the US territories based on the patient's address and must be insured by a commercial insurer that covers QUTENZA and does not prohibit participation in patient assistance programs. Uninsured or cash-paying patients and patients with coverage for QUTENZA through federal- or state-funded government healthcare programs, including Medicare, Medicaid, Medigap, TRICARE, Veterans Affairs (VA), or Department of Defense (DoD), are not eligible for the Program, with the exception of the Federal Employees Health Benefit (FEHB) Program for the purpose of this Program. A patient who begins receiving benefits for QUTENZA from a government healthcare program will no longer be eligible for the Program.

2. This Program will only accept applications by mail. No phone or email requests will be accepted or honored. Applications must be fully completed based on the instructions stated on the registration form. Averitas Pharma, Inc., is not responsible for lost, late, damaged, misdirected, incomplete, or illegible submissions. All submissions become the property of Averitas Pharma, Inc., and its agents. Please retain copies of any materials you submit.

3. Any refund under this Program may not exceed the eligible patient's medication and/or administration co-payment, co-insurance, or deductible costs ("Patient Responsibility") for QUTENZA, whether covered under the medical or pharmacy benefit. For pharmacy claims associated with the medication, this offer can be used only with a valid QUTENZA prescription at the time the prescription is filled by the pharmacist and dispensed to the patient, and is good only at participating pharmacies in the US.

4. The Program is valid for the patient's out-of-pocket costs for the medication and cannot be used if the patient is eligible to be reimbursed for the entire cost of QUTENZA. The patient and the patient's healthcare provider may not seek any other reimbursement of Patient Responsibility for the medication.

5. The Program is valid for the patient's total out-of-pocket costs for the administration of QUTENZA and cannot be used if the patient is eligible to be reimbursed for the cost of the administration of QUTENZA. The patient and the patient's healthcare provider may not seek other reimbursement of Patient Responsibility for the administration of QUTENZA. Applications for the full refund for the administration of QUTENZA are not eligible for the Program and will not be approved if the healthcare provider's administration costs are not covered or reimbursed by the patient's insurance.

6. Patient Responsibility for the medication must be isolated on the claim and separate from other services and products. A patient may not apply for reimbursement of Patient Responsibility under the Program if the patient's healthcare provider has already sought reimbursement under the Program, and the patient's healthcare provider may not seek such reimbursement of Patient Responsibility under the Program if the patient has already applied for reimbursement under the Program.

7. Refunds will be processed in the order in which they are received. Approved claims will be processed and paid in the subsequent billing cycle. Please allow approximately 4 weeks for delivery of refund checks. Tampering with, altering, or falsifying payment information is prohibited by law.

8. The Program is effective as of January 1, 2024, for treatments administered after this date. This offer is limited to 1 per person, is nontransferable, and is valid for the eligible patient only. No other purchase is necessary. This offer has no cash value and cannot be combined with any other patient assistance program, free trial, discount, prescription savings card, or other offer. Averitas Pharma, Inc., reserves the right to cancel, modify, or rescind this Program at any time. Aggregate and non-identifiable patient information may be used by Averitas Pharma, Inc., for market research and other related purposes. This Program is not insurance and is not intended to substitute for insurance. This offer is void where prohibited or restricted by law.