RELiZORB®
(iMMOBILIZED LIPASE) CARTRIDGE

PATIENT ASSISTANCE PROGRAM

Uninsured and Not Covered by Insurance

Application for Patient Assistance

RELiZORB is available at no cost to patients experiencing financial difficulties. Eligible patients typically have no healthcare coverage for the requested product and do not have access to alternative sources of coverage or funding. All applications are reviewed on a case-by-case basis to support the RELiZORB Patient Assistance Program's purpose of providing products at no cost to individuals in need.

Checklist for Submitting an Application:

- ☐ Ensure all sections of the application are completed
- ☐ Attach current proof of income (tax return – preferred) for all in household
- ☐ Patient's signature/date is required on back

Please complete this form and email or fax to RELiZORB Support Services at info@relizorbsupport.com or 1-844-233-3146.

ALCRESTA THERAPEUTICS

RELiZORB®
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Patient Certification for Patient Assistance (required)

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the RELiZORB Patient Assistance Program ("PAP") as determined by Alcresta from time to time. I agree that the PAP does not have any obligation to provide products or services to me. I understand that by completing this form I am not guaranteed eligibility to receive RELiZORB at no cost from the PAP. If I am eligible for the PAP, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the PAP. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP will no longer be provided. I agree that I will not seek reimbursement for any products dispensed under the PAP from any government program or third-party insurer. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes.

Patient's Name: _____

Signature: _____ Date: _____

Number of Household Members: _____

Representative Name (if applicable): _____ Relationship: _____

Representative Signature: _____ Date: _____

Personal Representative Representation (if applicable)

Note: A Patient's Personal Representative may sign this form on behalf of the patient. However, only certain individuals may qualify as the Patient's Personal Representative. A state law prescribes who can be a Personal Representative for purposes of this authorization.

By signing below, I represent that I am an authorized Personal Representative of the patient under applicable state law.

Representative Name: _____ Relationship: _____

Signature: _____ Date: _____

Additional Permission for Purposes of the Program (optional)

I permit the RELiZORB Patient Assistance Program to speak with the following person about this application:

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____ Phone Number: _____

Income Eligibility for Alcresta Patient Assistance Program

- Patients must be under 500% of the federal poverty level guidelines*
- For families/households with more than 8 persons, add $4,420 for each additional person*

*For the 50 Continental States and District of Columbia. Source: https://aspe.hhs.gov/poverty-guidelines. Accessed January 13, 2020.

Call 1-844-632-9271 to reach RELiZORB Support Services, or visit www.relizorb.com for more information.