

Makena™ Patient Assistance Program

Please return the completed application form and required documentation to:
Makena Cares Foundation, 6900 Dallas Parkway, Suite 200, Plano, TX 75024



STEP 1 — Patient Information (Complete as much information as possible)

Name (Please PRINT First, Middle Initial, Last)		DOB: Month/Day/Year	Social Security #
Street Address		City	State ZIP
Home Phone	Work Phone	Parent/Legal Guardian, <i>if appropriate</i>	Relationship

STEP 2 — Healthcare Provider Information (Required)

Name (Please PRINT First, Middle Initial, Last)	Telephone	Fax
Street Address	City	State ZIP

STEP 3 — Financial Information (Required)

Please indicate your annual household income:

- <\$20,000 \$20,000–<\$40,000 \$40,000–<\$60,000 \$60,000–<\$80,000 \$80,000–<\$100,000 \$100,000–>\$100,000

In order to process your Makena Patient Assistance Application you must check **one** of the boxes below and provide that supporting documentation with your application.

- A copy of the most recent year's tax return (IRS Form 1040 or 1040EZ) as well as a copy of the W2 form(s)
- One month's worth of pay stubs for the total household income
- A copy of the 1099 for total household income
- Signed letter from Social Security or government agency stating household income
- In the event that you did not file a federal tax return last year, provide a notarized statement of your annual household income
- If you are unable to provide any of the above documentation and your income is below \$20,000 per year **your healthcare provider must sign below attesting that you are unable to provide the documentation.**

Healthcare Provider/Healthcare Provider's Representative (required): _____ Date: _____

STEP 4 — Patient Certification, Disclaimer and Authorization

I verify that the information provided in this application is complete and accurate. I certify that I have no government or private prescription drug insurance coverage and do not have financial resources to pay for the prescription. I understand that Makena Cares Foundation reserves the right at any time and without notice to modify the eligibility criteria or discontinue the program at any time. I authorize Makena Cares Foundation and its agents to use the information on this application for the purposes of processing and verifying my request for Makena and for record keeping. I understand that if my health insurance coverage or financial status changes, I will notify the Makena Cares Foundation promptly of such change. I understand that this may affect my eligibility to participate in the program before my eligibility period ends. I also understand that any and all information that I provide may be shared with my treating healthcare provider and Ther-Rx Corporation, the supplier of Makena and supporter of the Makena Cares Foundation or its agents or affiliates. I understand that this Authorization will expire 12 months from the date signed below. The Makena Cares Foundation agrees not to disclose any information obtained from these sources to any third party except for the purposes described in this Authorization or as required by applicable law. Participation in the program is not guaranteed to all applicants. The Makena Patient Assistance Program does not cover or provide support for supplies, procedures, or any healthcare provider-related services, including injection support associated with Makena therapy. Patients must re-apply for each qualifying pregnancy.

Patient Signature (original signature required): _____ Date: _____

Parent/Legal Guardian Signature (if appropriate): _____ Date: _____