Co-pay Assistance Program
Patient Reimbursement Form

The NS Support Co-pay Assistance Program ("the Program") Patient Reimbursement Form may only be completed by the patient or the patient's authorized representative. This form may be submitted, along with all required documentation, for the patient to receive reimbursement from the Program for amounts the patient has paid towards the cost of VILTEPSO® (viltolarsen), consistent with the Program Terms and Conditions. The patient is responsible for any amounts not covered by the Program.

If you have any questions about submitting this claim, please call NS Support at 833-NSSUPRT (833-677-8778), Monday–Friday, 8:00 AM to 8:00 PM ET.

Submission instructions:

1. Fill out sections A, B, and C, and sign and date Section D.
2. Attach a copy of the Explanation of Benefits (EOB) setting forth the amount the patient's private insurance company indicates the patient is required to pay for VILTEPSO.
3. Attach an invoice from the treatment provider's office (or specialty pharmacy), which includes the following information:
   - Name and address of treatment provider or specialty pharmacy
   - Name of patient
   - Patient ID
   - Date of service
   - VILTEPSO or HCPCS Code
   - Amount billed to patient for VILTEPSO
4. Attach proof of payment by the patient to the treatment provider or specialty pharmacy for the patient's out-of-pocket cost for VILTEPSO (eg, credit card receipt, photocopy of cleared check).
5. You may submit the requested documentation via fax at 888-654-1121 or mail to NS Support at PO Box 29203, Phoenix, AZ 85038-9203.

SECTION A: PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ DOB (MM/DD/YYYY) _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECTION B: PROVIDER INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECTION C: CLAIM INFORMATION

PATIENT ID _____ DATE(S) OF SERVICE _____ AMOUNT BILLED TO PATIENT _____

SECTION D: PATIENT SIGNATURE

I certify that, to the best of my knowledge, the information on this reimbursement form is true and correct. By submitting this request, I certify that I have read the Terms and Conditions of the NS Support Co-pay Assistance Program and that I am eligible to receive co-pay assistance from the Program on the claim I am submitting for reimbursement. I certify that I do not have Government Program insurance, as that term is defined in the Terms and Conditions of the NS Support Co-pay Assistance Program, and that I have paid my treatment provider or specialty pharmacy for my share of the cost of VILTEPSO, as determined by my private health insurance company. I understand that I am responsible for reporting receipt of NS Support Co-pay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Program, as may be required. I authorize the release of any medical information to third parties working on behalf of NS Pharma, Inc. necessary to process this request for co-pay assistance.

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) SIGNATURE _____ DATE _____

PARENT/GUARDIAN/LEGAL REPRESENTATIVE/PATIENT (IF OVER 18) PRINT NAME _____

RELATIONSHIP TO PATIENT _____

Clear Form Print Form

Co-pay Assistance Program Eligibility Requirements & Terms and Conditions

- You must be a citizen or a permanent resident of the US or its territories and reside in the US or its territories where co-pay assistance is not prohibited.
- You must not be enrolled in government health insurance (eg, Medicare, Medicaid, Indian Health Service, Veterans Administration, Department of Defense, or any other federal or state government assistance programs). If you move or switch from commercial insurance to any government-funded insurance, you will no longer be eligible.
- You are being treated as an outpatient by a licensed healthcare provider in the US and have been prescribed VILTEPSO® (viltolarsen) by a licensed healthcare provider.
- You currently have private, commercial health insurance with prescription coverage for VILTEPSO medication, and your insurance does not cover the entire cost of VILTEPSO.
- You are under age 65.
- There is no income requirement.
- The Program covers only the cost of VILTEPSO and not the cost of any infusion services or healthcare provider visits, which are the sole responsibility of the patient.
- You will be automatically re-enrolled every 12 months as long as you continue to meet the eligibility requirements for participation in the Program.
- You are responsible for reporting receipt of co-pay assistance to any insurer, health plan, or other third party who pays for or reimburses any part of the medication or treatment cost using the NS Support Co-pay Assistance Program, as may be required.
- You must not seek reimbursement, in whole or in part, from government health insurance (eg, Medicare, Medicaid, Indian Health Service, Veterans Administration, Department of Defense, or any other federal or state government assistance programs), a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).
- You will not in any way report or count the value of the product provided under this Program as true out-of-pocket spending (TrOOP) under a Medicare Part D prescription drug benefit.
- Claims must be submitted in a timely manner. An EOB from your private, commercial health insurance must be submitted within 365 days of the date of service on the EOB for you to receive a co-pay assistance benefit. No EOB may be submitted more than 90 days after the expiration date of the Co-pay Assistance Program, and the date of service on the EOB must be prior to the program expiration date. The EOB must reflect your out-of-pocket cost for VILTEPSO and submission of the claim by your physician for the cost of the medication.
- The NS Support Co-pay Assistance Program is not health insurance.
- NS Pharma, Inc. has the right to modify, alter, or cancel the NS Support Co-pay Assistance Program at any time without prior notification.