Patient Support Enrollment Form

Please complete all fields with black ink and fax form to 1-844-286-5445.
For help, please call 1-844-MELINTA (1-844-635-4682).

MelintAssist℠ Your Path to Access

Baxdela™ (delafloxacin) 450 mg tablets 300 mg vial for injection

EXPECTED HOSPITAL DISCHARGE DATE: _____/_____/_____

DISCHARGE FORMULATION FOR BAXDELA: ☐ TABLETS ☐ IV

PATIENT INFORMATION

Name: (First) _____ (Last) _____
DOB (mm/dd/yyyy): ___/___/_____ Gender: ☐ Male ☐ Female
Last 4 of SSN* (If no SSN, refer to the PATIENT ASSISTANCE section on Page 2): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (___)___-_____ Mobile Phone: (___)___-_____
Email: _____
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

POST DISCHARGE INFORMATION

Physician Name: _____
Phone: (___)___-_____ Fax: (___)___-_____
Address: _____
City: _____ State: _____ Zip Code: _____

PATIENT CLINICAL INFORMATION

Diagnosis/ICD-10-CM: _____
Names of Prior Therapies: _____
_____

BAXDELA IV

☐ 300-mg IV infusion q12h Date of Service: _____

BAXDELA TABLETS

One time, 2 day Prescription for Baxdela (delafloxacin)
☐ 450-mg tablet every 12 hrs for 2 days Quantity: 4
* By selecting this option you are choosing to request a one time, free dose of medication. Eligibility criteria may apply.

Prescription for Baxdela (delafloxacin)
☐ 450-mg tablet every 12 hrs for ___ days
Other: Sig _____ Quantity: _____ Refills: _____

Start Date (mm/dd/yyyy): ___/___/_____
In Combination With (If Applicable): _____
Continuation of Care? ☐ Yes ☐ No
Ship to Patient's Home? ☐ Yes ☐ No (If no, complete information below)
Preferred Pharmacy: _____
Phone: (___)___-_____ **Fax:** (___)___-_____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

PRESCRIBER INFORMATION

Prescriber Name: (First) _____ (Last) _____
Prescriber Tax ID #: _____ DEA #: _____
State License #: _____ NPI #: _____
Prescriber Phone: (___)___-_____
Name of Facility: _____
Facility Street Address: _____
City: _____ State: _____ Zip Code: _____
Office Contact Name: (First) _____ (Last) _____
Office Contact Phone: (___)___-_____ Fax: (___)___-_____
Email: _____

PATIENT INSURANCE INFORMATION

Medical Insurance Company: _____
Name of Insured (Cardholder): _____
Policy #: _____ Group #: _____
Plan Phone: (___)___-_____
Member ID #: _____
Prescription Drug Plan Name: _____
Name of Insured (Cardholder): _____
Policy #: _____ Group #: _____
Plan Phone: (___)___-_____
BIN #: _____ PCN #: _____

BAXDELA IV COPAY SAVINGS PROGRAM PAYMENT

PRESCRIBER BILLING INFORMATION (Payment for copay requests will be sent to the address below)

Same as facility address: ☐ Yes ☐ No (If No, complete information below)

Contact Name: _____
Phone: (___)___-_____
Billing Address: _____
City: _____ State: _____ Zip Code: _____

For more information on eligibility criteria, please contact MelintAssist at: 1-844-MELINTA (1-844-635-4682).

PRESCRIBER ATTESTATION

Prescriber Signature: Sign here _____ Date of Signature (mm/dd/yyyy): ___/___/_____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION (NO STAMPS): I certify that I made the prescribing decisions indicated above based on my own independent medical judgment regarding what is in the best interest of the patient and that I have reviewed the current Baxdela Prescribing Information. I authorize Melinta Theraputics, its employees, agents, and subcontractors providing services on Melinta's behalf ("the MelintAssist Program") to act on my behalf to transmit this prescription to the pharmacy as indicated above. My signature confirms that I have read, agree, and understand that the information provided in this MelintAssist Enrollment Form is complete and accurate to the best of my knowledge. I understand that Melinta Theraputics Inc. reserves the right at any time and for any reason, without notice, to modify this referral form or to modify or discontinue any services or assistance provided through MelintAssist. I authorize the MelintAssist Program as my designated agents to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through MelintAssist, (as applicable) to assess my patient's eligibility for copay assistance and for quality and data assurance purposes. My patient has provided a signed HIPAA Authorization that allows me to share protected health information with the MelintAssist Program for purposes of participating in the Program. To the best of my knowledge, all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that the Program is relying on this representation. I agree that the MelintAssist Program may contact me and my office via telephone, fax, and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time. Finally, I further certify that I made the above prescribing decisions based on my own independent medical judgment regarding what is in the best interests of the patient.

Please see full Prescribing Information, including **Boxed Warning**, and the Patient Medication Guide. Ensure the Medication Guide is provided to your patients.

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First Name: _____ Last Name: _____ Date of Birth: _____

PATIENT ASSISTANCE INFORMATION

1. Is the patient a United States resident? ☐ Yes ☐ No
2. Annual household income: $_____ Please attach documentation
3. How many people, including the patient, live in the household? _____
4. Is the patient currently enrolling in Medicaid? ☐ Yes ☐ No
5. Individual authorized by the patient to act as their representative:
   Authorized Representative: _____ Relationship to Patient: _____ Phone: (___)___-_____

*If the patient does not have a SSN or chooses not to provide it, please contact MelintAssist for other acceptable forms of documentation.

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I understand that I am submitting this application to the MelintAssist Program (Program), or my doctor's office is submitting it on my behalf, to assess my eligibility for assistance in obtaining Baxdela, and other services, to help me find possible sources of financial assistance, or to assess whether I have insurance coverage for Baxdela. I understand that before the Program can assist me, it may need to collect, use, and disclose information about me that is requested on this application, including my Protected Health Information ("PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA")), my financial information and other personal information about me (collectively "My Personal Information"). PHI that will be disclosed includes any information related to my healthcare insurance or plan benefits, including coverage limits and other information related to my health.

I understand that by signing this form, I am permitting my Healthcare Provider (including my Nurse, Case Manager, or anyone else involved in my treatment), my healthcare plan or insurance company, my pharmacies, as well as other entities that may hold my PHI, to release My Personal Information, including my PHI, to the Program agents who may be assisting with the administration of the patient assistance programs. I understand that to provide the services for the patient assistance programs, Program Agents may need to further disclose My Personal Information to and communicate with other agents involved with patient assistance programs, my treating Physician or other health care providers, including my insurance company or health plan or pharmacies.

I further understand that the Program Agents will use My Personal Information in the following manner: (1) to review my application for patient assistance programs; (2) to help determine my healthcare plan coverage for Baxdela by conducting reimbursement verifications (3) to contact me or my Physician or any other of my health care providers, as necessary, to conduct such services via mail, telephone, fax, or e-mail; and (4) providing me with educational support services by mail, text, messaging, email and/or telephone and (5) referring me to, or determining my eligibility for other programs, including alternative sources such as foundation support or access to the MelintAssist Patient Support Program (PAP) coverage to help me with the cost of Baxdela. I understand that I do not have to sign this consent, but if I do not, the Program cannot provide the described services. I understand that I might need to pay for Baxdela on my own, whether I sign this form or not. I understand that once my doctors, healthcare plan, pharmacies, or others who have my Protected Health Information release it, my information may no longer be covered by Federal Privacy Law (for example, HIPAA). This authorization allows those who rely upon it to release my Protected Health Information for 3 years from the date of my signature.

I understand that I can withdraw this authorization at any time by sending a written request to the mailing address below. My withdrawal of my consent will go into effect once it is received by the Program. I also understand that by withdrawing the authorization, I may stop receiving the services provided under this program.

Patient's Signature: Sign here _____ Date of Signature: ____/____/_____

Printed Name: _____

Parent/Guardian/Authorized Representative's Signature: Sign here _____ Date of Signature: ____/____/_____

Printed Name: _____ Relationship to Patient: _____

PATIENT AUTHORIZATION TO DISCLOSE TO AUTHORIZED PARTIES

In order to protect your privacy we will not share your information with unauthorized individuals. Please list the names of anyone authorized to have access to your medical information. Only the individuals listed below will be given information regarding your medical condition. I hereby authorize the MelintAssist Program, its staff, my Healthcare Provider (including my Nurse, Case Manager, or anyone else involved in my treatment) to disclose my protected health information to the following representative:

Name: _____ Phone Number: (____)_____-_____

Relationship to Patient: _____

Patient's Signature: Sign here _____ Date of Signature: ____/____/_____

Name: _____ Phone Number: (____)_____-_____

Relationship to Patient: _____

Patient's Signature: Sign here _____ Date of Signature: ____/____/_____

Please see full Prescribing Information, including **Boxed Warning**, and the Patient Medication Guide. Ensure the Medication Guide is provided to your patients.

Mail us at
MelintAssist Patient Support
2250 Perimeter Park Drive
Suite 300
Morrisville, North Carolina 27560

Call us at
1-844-MELINTA (1-844-635-4682)
Monday - Friday, 8 AM - 8 PM ET

Fax us at
1-844-286-5445