Solesta PAP Enrollment
Phone: 844-350-9656 **Fax:** 513-506-7361
PO Box 428710 Cincinnati, OH 45242

Please fill out the following information and submit to Palette, along with the required documentation.

Request Type	
☐ 1st Treatment 1 Carton (Contains 4 – 1mL Syringes)	☐ 2nd Treatment 1 Carton (Contains 4 – 1mL Syringes)
PHYSICIAN INFORMATION	
Physician First & Last Name:	Physician NPI:
Practice Name (If Applicable):	
Provider/Practice Address:	
Provider/Practice Phone Number:	Provider/Practice Fax Number:
Practice Contact Name & Phone Number (If Applicable):	
Physician Signature: _____	Date: _____
PATIENT INFORMATION	
Patient First & Last Name:	
Patient Address:	
Patient DOB:	Patient Phone Number:
Number of people within household:	Household Income:
Diagnosis:	

To qualify for assistance you must:

- Have been prescribed Solesta®;
- No medical insurance coverage
- Meet certain income limits (income eligibility starts at 300% of the current Federal poverty guidelines and varies by household size. Income eligibility will be assessed upon receipt of your completed application).

Please submit documentation to support the financial information you've listed above. Attach your most recent **federal tax return, W-2 form, or two recent paystubs**.

The information you provide will be used by Palette Life Sciences, Palette Life Science Services, LLC ("Palette"), and parties acting on their behalf to determine eligibility, to manage and improve the Solesta® Patient Assistance Program (PAP), to communicate with you about your experience with the Solesta® PAP, to help you understand your insurance coverage, to help you access Solesta®, and/or to send you materials and other helpful information and updates.

By signing below, I certify that I cannot afford my Solesta® and do not have insurance, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I understand that:

- Completing this application does not guarantee that I will qualify for the program..
- Palette may verify the accuracy of the information I have provided and may ask for more financial and insurance documentation.
- Any Solesta ® supplied by the Solesta® PAP shall not be sold, traded, bartered, or transferred.
- Palette reserves the right to change or cancel the PAP, or terminate my enrollment, at any time.
- The support provided through this program is not contingent on any future purchase.

I certify and attest that if I receive Solesta® provided by Palette through the Solesta® Patient Assistance Program:

- I will promptly contact the Solesta® PAP if my financial status or insurance coverage changes.
- I will not seek reimbursement or credit for the Solesta® from my insurance prescription provider or payor.
- I have a signed copy of a current and completed HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with Solesta's PAP and agents of Palette Life Sciences.

Patient Full Name:_____ Date: _____
Patient Signature (or Caregiver):_____ If Caregiver, relationship to patient: _____
Phone:_____ Email address: _____