Sculptra®

GALDERMA

ALL SECTIONS ARE REQUIRED

Patient Information

Name______________________________

Address______________________________

City________________State______Zip______

Social Security Number________________

Patient Gender: ☐ Male ☐ Female

Date of Birth ________________

Phone # ________________

Patient Representative for Purposes of Program (if applicable)
I permit the Galderma Patient Assistance Program for Sculptra® to speak and write to the following person(s) about this form, and I permit the person(s) to sign any documents related to the Program on my behalf:

Name:________________Relationship:__________Phone:__________

1. Is the patient a U.S. resident? ☐ Yes ☐ No

2. Does the patient have DRUG COVERAGE for Sculptra?
   - Private plan (such as HMO or PPO) ☐ Yes ☐ No
   - Medicare Prescription Drug ☐ Yes ☐ No
   - Other Government coverage ☐ Yes ☐ No e.g.: Medicaid, Veteran's Administration, state or local programs

3. What is the gross HOUSEHOLD INCOME including wages, social security, disability, etc.?
   $________________YEARLY OR $________________MONTHLY

4. How many people, including the patient, live in the household? (Please circle) 1 2 3 4 5 6 7+

By signing this Authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Galderma Laboratories, L.P. — the Galderma Patient Assistance Program —and its representatives, agents, and contractors (collectively "Galderma") for the following purposes: (1) to establish my eligibility for Program benefits; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to contact me with branded support materials related to my treatment. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Galderma Patient Assistance Program, PO Box 640 Somerville, NJ 08876, but that this cancellation will not apply to any information already used or disclosed through this Authorization.

By signing this Authorization, I affirm all of the following: (1) I am a legal resident of the United States; (2) I do not have private insurance; (3) I am not enrolled in Medicare Part D, Medicare, Medicaid, MediGap, VA, DOD or Tricare, or any other government-run or government sponsored health care program with a pharmacy benefit or where prohibited by law; (4) I do not qualify and do not participate in any State or Federal assistance for prescription medications; (5) my total household income is at or less than the guidelines set by the program; (6) the prescription medication requested is for me or the identified patient listed above; and (7) I will not sell, trade or use the medication for any other purpose then its intended and prescribed use.

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Patient or legal guardian's signature Date
(Stamped signatures will not be accepted)

Galderma Patient Assistance Program for Sculptra®
P.O. Box 430 Somerville, NJ 08876
Telephone: 866-310-7551; Fax: 866-364-2016

Galderma Laboratories, L.P. reserves the right to rescind, revoke or amend Program offerings at any time.