Zilretta®
triamcinolone acetonide extended release injectable suspension 32 mg

ZILRETTA® Copay Assistance Program Patient Application

Please complete all fields with black ink and fax form to 855.915.3006.
Or mail to The ZILRETTA Copay Assistance Program
2250 Perimeter Park Drive, Suite 300
Morrisville NC 27560

For fastest processing, please complete all *required fields.

Patient Information

*Name: (First)_____ (Last)_____ *DOB (mm/dd/yyyy):____/_____/_____ *Gender: ❒ Male ❒ Female

*Address: _____ *City: _____ *State: _____ *ZIP Code: _____

Home Phone: (____) _____-_____ Mobile Phone:(____) _____-_____ Email: _____

*Insurance Carrier: _____ *Insurance Plan: _____

Prescriber Information

If you are completing this section as a patient, please be sure to verify this information with your provider's office.

*Prescriber Name: (First)_____ (Last)_____ NPI #: _____

*Name of Treatment Site or Practice: _____

Facility Street Address: _____ City: _____ State: _____ ZIP Code: _____

Office Contact Name: (First)_____ (Last)_____ *Office Contact Phone: (____) _____-_____ Fax: (____) _____-_____

Office Contact Email: _____

Patient Signature for Terms & Conditions

Patient Authorization to Disclose PHI and consent to the ZILRETTA® Copay Assistance Program Terms & Conditions

I authorize Flexion Therapeutics, Inc. and its agents to use and disclose my protected health information (PHI) as necessary to verify the accuracy of any information provided, to provide services through the ZILRETTA Copay Assistance Program, and (as applicable) to assess eligibility for copay assistance, according to Program Terms and Conditions. I understand that my PHI may be used, disclosed, or transferred by Flexion Therapeutics, Inc., and its agents for communications, marketing, and internal business purposes, including providing me with educational and support services, materials and information related to ZILRETTA and knee osteoarthritis or contacting me by mail, email, and/or telephone to ask me about my experiences with, or thoughts about, products, services, and programs that Flexion Therapeutics and/or its agents offers or sponsors, and to help Flexion Therapeutics, Inc. develop new products, services, and programs. I understand that the companies working with Flexion Therapeutics, Inc. receive compensation for the services that they provide.

ZILRETTA Copay Assistance Program Terms & Conditions

I verify that I have read and understand the ZILRETTA Copay Assistance Program Terms and Conditions. Patient must have commercial health insurance that covers the medication costs of ZILRETTA. Patients are not eligible if prescriptions are paid, in whole or in part, by federal or state subsidized healthcare program that covers the cost of ZILRETTA, including Medicare, such as Medicare Part D prescription drug benefit, Medicaid, TRICARE, a qualified health plan (QHP), Federal Employee Program (FEP), or any other federal or state healthcare plan, including pharmaceutical assistance programs, or where prohibited by law. The ZILRETTA Copay Assistance Program covers ONLY the out-of-pocket cost of ZILRETTA, up to an annual maximum dollar limit. The ZILRETTA Copay Assistance Program does not cover administrative or office visit costs. Cash patients are not eligible for this offer. Patient is responsible for reporting receipt of copay assistance to any insurer, health plan, or other third party who pays for or reimburses any part of the prescription filled, as may be required. The ZILRETTA Copay Assistance Program is available for patients residing in the US, Puerto Rico, or US Territories. Flexion Therapeutics reserves the right at any time and for any reason, without notice, to modify this Program Application or to modify or discontinue any service or assistance provided through the Copay Assistance Program.

You have a right to receive a copy of this form after you sign it.

You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please contact 1-844-248-7732.

Patient Signature: _____ Date: _____