RADIESSE®
VOLUMIZING FILLER
for FACIAL LIPOATROPHY

RADIESSE® Patient Access Program

We are pleased to offer the RADIESSE Patient Access Program. Merz North America is committed to helping people with HIV associated facial lipoatrophy gain access to RADIESSE treatment. To help fulfill this commitment, we have developed the RADIESSE Patient Access Program which provides access for those patients who qualify for assistance. RADIESSE is intended for restoration and/or correction of the signs of lipoatrophy in people with human immunodeficiency virus (HIV).

WHO IS ELIGIBLE?

In order to qualify for the program, the patient must:

- Be diagnosed with facial lipoatrophy associated with HIV
- Lack, and not be eligible for, any insurance or healthcare coverage, whether private or governmental, on the procedure
- Earn less than $80K per year
- Be at least 18 years old

RADIESSE PATIENT ACCESS PROGRAM PRICING

ANNUAL INCOME		PRICE PER 1.5 CC SYRINGE
< $40,000	→	$100
$40,000 – $50,000	→	$140
$50,001 – $60,000	→	$170
$60,001 – $70,000	→	$190
$70,001 – $80,000	→	$200

HOW DOES THE RADIESSE PATIENT ACCESS PROGRAM WORK?

1. Licensed physicians practicing in the US who have completed RADIESSE training, (and who have acknowledged receipt of materials regarding product use) may apply for the RADIESSE Patient Access Program on behalf of their patients who are eligible for the program because they earn less than $80,000.
2. A two page application form should be completed as follows: Physician completes page 1 and 2. The patient signs page one (patient information) and the physician signs page two (practice information). Please note that both patient and physician signatures verify that the product is for use consistent with the FDA approved product indication.
3. Physician obtains a photocopy of the patient's proof of annual income and sends the Application Form and Proof of Annual Income (e.g. W2, 1099 or similar form) to Merz North America.
4. Physician will be notified in writing (fax or email) within 5 working days that the application has been approved, denied, or needs additional information.
5. In accordance with the program rules, after the application has been approved, RADIESSE will be shipped to the physician within approximately 2 weeks from receipt of completed application; the physician will be billed at the approved Patient Access Program price. Up to six 1.5cc syringes per year per patient are available under the RADIESSE Patient Access Program.
6. Approval expires after (1) year. Future additional requests will have to be made through a re-application process.

TERMS AND CONDITIONS

Please Note: While Merz North America will attempt to provide access to the RADIESSE Patient Access Program for eligible patients, the Program is limited to available resources and may be discontinued or revised at any time without further notice.

For additional information or to get an application, please call 1-844-469-6379.

Send completed application to:

RADIESSE® Patient Access Program:	6501 Six Forks Rd Raleigh, NC 27615	Phone Fax	1-844-469-6379 1-866-862-1212

Your partnership is critical in helping to ensure treatment access, and we appreciate your participation in this important RADIESSE program.

RADIESSE is a prescription filler to help with the restoration and/or correction of facial fat loss in adults with HIV. Please refer to Important Safety Information on next page.

MERZ AESTHETICS®

RADIESSE®
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INDICATION

RADIESSE® has been approved for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.

RADIESSE® IMPORTANT SAFETY INFORMATION

RADIESSE Injectable Implants is FDA-approved for subdermal implantation for the correction of moderate to severe facial wrinkles and folds, such as nasolabial folds or correction of the signs of fat loss (lipoatrophy) in people with human immunotherapy virus.

RADIESSE is contraindicated for patients with severe allergies, known hypersensitivity to any of the components of RADIESSE and patients with bleeding disorders. Introduction of the product into the vasculature may lead to embolization, occlusion of the vessels, ischemia, or infarction.

Common adverse events seen in clinical studies of RADIESSE include bruising, redness, swelling, pain, and itching.

For complete safety information, including information on adverse events from post-market surveillance of RADIESSE, please refer to the Instructions for Use at Radiesse.com. To report a problem with RADIESSE, please call MyMerz Solutions at 1-844-469-6379.

Caution: Rx only

For Instructions for Use Document and Complete Safety Information please go to www.radiesse-fl.com or call MyMerz Solutions at 1-844-469-6379.

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Patient Access Program Application Form

PATIENT INFORMATION (Application to be filled out by practitioner and signed by patient)

Name of Patient	Date of Birth		
Address	City	State	Zip
Phone Number	Alternative Phone Number		

Please complete the following information:

1. Patient's ANNUAL income, including social security and pension benefits: $ _____
   (Please include supporting documentation such as W2, 1099 or similar form)
2. The product use for this patient is consistent with the following FDA-approved indication for RADIESSE : RADIESSE® is **intended for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.** Yes No
3. Does patient qualify for insurance coverage for RADIESSE in a public program? Yes No
   If yes, patient is not eligible for assistance program

RADIESSE is a prescription filler that has been approved for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.

Please refer to Important Safety Information on page 3.

PATIENT STATEMENT AND AUTHORIZATION

By signing this document, I hereby give my consent to my healthcare provider and Merz North America, Inc. (Merz North America), including their representatives and vendors, to obtain, use and disclose information about my health insurance coverage and income for purposes of determining my eligibility for the RADIESSE Patient Assistance Program (PAP). The parties authorized to disclose such information also include my health insurer if any, employer(s), and any of my healthcare providers.

I understand that Merz North America reserves the right to modify or discontinue the RADIESSE Patient Assistance Program and its eligibility criteria at any time without further notice to me. I have read this document and understand it. The information I have provided above, including my income and insurance information, is complete and accurate. I represent that I do not have, and am not eligible for, any insurance or healthcare coverage, whether private or governmental, for RADIESSE treatment.

Patient's Signature	Date

☐ Check box if you consent to Merz contacting you directly.

RADIESSE Patient Access Program:
6501 Six Forks Rd
Raleigh, NC 27615
Phone 1-844-469-6379
Fax 1-866-862-1212

MERZ AESTHETICS®

Patient Access Program Application Form

PRACTICE INFORMATION

Physician's Name | Specialty

Facility Name | Account # (if new customer - leave blank)

Address (PRODUCT SHIPMENT PURPOSES) | City | State | Zip

Phone Number | Fax Number

Provide one of the following:

DEA # | NPI # | State and State License #

Office Contact Name | Contact Phone Number

Email

INDICATION

RADIESSE is a prescription filler that has been approved for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.

Please refer to Indication and Important Safety Information on next page.

NUMBER OF SYRINGES REQUESTED (1.5cc per syringe) for the patient listed on the next page:

1 2 3 4 5 6

LICENSED PRACTITIONER STATEMENT:

I agree to administer the RADIESSE injectable implant provided under this application only to the patient listed below for the FDA-approved indication listed above and for no other purpose. I certify that the product provided hereunder will not be resold nor offered for sale, trade or barter and will not be returned for credit and the patient shall not be charged greater than the acquisition cost for product. To the best of my knowledge, the patient for whom I am requesting RADIESSE under this application does not have, and is not eligible for, any insurance or healthcare coverage, whether private or governmental, for RADIESSE treatment. I understand that Merz North America reserves the right to modify or discontinue the Patient Access Program and its eligibility criteria at any time without further notice.

Name of Patient for whom product is being requested

Licensed Physician's Signature | Date

For Internal Use Only: (circle as appropriate, sign and date)					
Approved	Not Approved	Training Confirmed: Yes / No	Price per 1.5 cc syringe: $100 / $140 / $ _____	Signature	Date

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