Dexcom Patient Assistance Program

Dexcom will provide eligible patients in the United States who are experiencing financial hardship with up to two 90-day supply shipments of the Dexcom Continuous Glucose Monitor (CGM) System.

Dexcom understands that people living with diabetes may sometimes experience financial hardships that make it difficult to continue with their prescribed Dexcom CGM. To help patients maintain treatment without interruption, the Dexcom Patient Assistance Program will provide patients with up to two 90-day supply shipments of Dexcom CGM (including transmitter and sensors) at a reduced price of $45 per shipment (eligibility requirements are subject to change at Dexcom's discretion).

Patients may be eligible for the Dexcom Patient Assistance Program if they:

- Are living with Type 1 diabetes
- Are 2 years of age or older
- Do not currently receive benefits from federal healthcare programs (for example, Medicare, Medicaid, TRICARE)
- Have a gross annual household income of 400% or less of the current year's Federal Poverty Level (FPL) in relation to the number of household members, and provide documentation, including at least one of the following:
  - A copy of their most recent US Income Tax Return, W-2 Form, or 1099 Form
  - A copy of a Social Security or Disability Award Letter, benefit statement or check
  - Copies of pay stub(s) for the past three month(s) or a signed and dated letter stating that there is no income
  - A copy of an unemployment benefits statement
- Are able to receive shipments of the Dexcom supplies in a U.S. State, District of Columbia, or Puerto Rico

For further information on the FPL in your state, please visit the HealthCare.gov website at **www.healthcare.gov/glossary/federal-poverty-level-fpl/**

Instructions for Enrollment

COMPLETE THE APPLICATION ON THE NEXT PAGE AND SUBMIT WITH REQUIRED DOCUMENTATION TO:

FAX	MAIL
833-235-9633	Dexcom Patient Assistance Program PO Box 70 Chesterfield, MO 63006

Upon receipt of a completed application, you will be notified of your eligibility for the Dexcom Patient Assistance Program. If you are eligible for assistance, Dexcom CGM supplies will be shipped to the mailing address Dexcom has on file for you.

Submission of an application does not guarantee eligibility for the Dexcom Patient Assistance Program. All applications must be reviewed before eligibility can be determined. This program may be modified or discontinued by Dexcom at any time.

If you have questions, need additional assistance, or would like additional applications, please contact us at 833-235-9634, Monday through Friday, 11 am to 6 pm ET.

SUBMIT THIS PAGE
Dexcom Patient Assistance Program

dexcom
CONTINUOUS GLUCOSE MONITORING

PATIENT INFORMATION

Patient Name: _____ Gender: ☐ Male ☐ Female
(First, Middle, Last)

Shipping Address: _____ City: _____ State: _____ ZIP: _____
(Street Address – cannot be PO Box) (Apt/Suite)

Date of Birth: _____/_____/_____(mm/dd/yyyy) Social Security Number: _____

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

Best way to contact you (check all that apply): ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Mail

Physician Name: _____ Physician Phone: (_____) _____
(First, Last)

Physician Address: _____ City: _____ State: _____ ZIP: _____
(Street Address) (Apt/Suite)

Are you a patient currently using a Dexcom CGM System? ☐ Yes ☐ No

Do you currently have insurance coverage for your Dexcom CGM System? ☐ Yes ☐ No ☐ N/A

Where have you obtained your sensors from in the past? ☐ Retail Pharmacy ☐ Dexcom ☐ DME Distributor

If from a pharmacy, please provide: Pharmacy Name: _____ Pharmacy Phone: (_____) _____

What is your household size? Please include yourself and the number of people who live in your home and are dependent on your income. _____

PLEASE SUBMIT DOCUMENTATION THAT SHOWS PROOF OF INCOME WITH YOUR APPLICATION.

Submit at least one of the following:

- A copy of your most recent US Income Tax Return, W-2 Form, or 1099 Form
- A copy of a Social Security or Disability Award letter, benefit statement, or check
- Copies of your pay stub(s) for the past three month(s) or a signed and dated letter stating that there is no income
- A copy of an unemployment benefits statement

I understand that any assistance I receive from Dexcom in the form of CGM supplies (at the discounted rate of $45 per shipment of 90 days of Dexcom CGM supplies) is contingent upon my ability to meet the eligibility criteria for the Dexcom Patient Assistance Program. I understand that this program may change or be discontinued at any time without any notice to me. Further, I certify and state under the penalty of perjury that:

- The information that I provide in this application, including any supporting documentation, is accurate and complete to the best of my knowledge
- I am not a recipient of federal healthcare program benefits (eg, Medicare, Medicaid, TRICARE)
- I understand that submission of an application does not guarantee eligibility for the Dexcom Patient Assistance Program
- I will not seek reimbursement for any products dispensed from the Dexcom Patient Assistance Program from any source, including any third-party insurance carrier

Patient Signature: _____ **Date:** _____

Personal Representative Authorization (if applicable): If the Patient is unable to sign, is under the age of 18 years old, or has designated signature authority, the Patient's Personal Representative may sign this application for purposes of this Authorization. However, only certain individuals may qualify as the Patient's Personal Representative for purposes of this Authorization (ie, the Personal Representative must have the requisite knowledge and information regarding the Patient's financial and healthcare status to verify that all responses provided are accurate).

Patient Representative Printed Name: _____ **Relationship:** _____

Patient Representative Phone: (___) _____

Patient Representative Signature: _____ **Date:** _____

Please fax the completed form and required documentation to 833-235-9633; or mail to Dexcom Patient Assistance Program, PO Box 70,

Chesterfield, MO 63006. If you have any questions or need additional assistance, please contact us at 833-235-9634.