BAUSCH + LOMB Patient Assistance Program

This Patient Assistance Program (the "Program") is intended to benefit patients by providing certain prescription medications free of charge to eligible patients who do not have private insurance or other coverage (including Medicaid, Medicare or any other federal or state government-funded program benefits) for such medications, either because they are uninsured or because their insurer has enied coverage for the specific medication, and who cannot afford to pay for their medication. To be considered for assistance from the Program, the patient must have an annual household income of less than $19,600 for one person or a combined family income of no more than $26,400.

A PRESCRIPTION IS REQUIRED FOR EACH REQUEST. A completed prescription for an eligible product (please refer to the list below) must be attached with an original signature of the prescribing physician. This completed form and the prescription must be returned by mail or fax 800-233-9141 to fulfill the request. Please mail to:

Bausch & Lomb Incorporated
US Patient Assistance Program
PO BOX 2235
Morrisville, PA 19067-8035

Thank you again for your interest in Bausch & Lomb pharmaceutical products. If you have any further questions, please call our customer service department at 800-323-0000.

Practitioner Name:	**State License #:** **Expiration Date:**	
Address:		
City:	**State:**	**Phone #:**
Zip:	**Fax#:**	
Ship to the Attention of:		

To the best of my knowledge based upon the information provided to me, the patient identified below: (1) does not have public or private prescription insurance coverage for the requested medication or has been denied coverage for the requested medication, and (2) meets the financial need criteria specified above.

My signature below certifies the following:

1. That the product I receive from the Program in response to this request is solely for the use by the patient identified below.
2. That I shall not seek reimbursement, or assist any patient to seek reimbursement, from any insurance provider or payer (public or private) for any of the products provided for free pursuant to the Program.
3. The products provided pursuant to the Program will not be resold nor offered for sale, sample, trade, barter, or used for any other purpose.
4. That the state license information and expiration date provided above is accurate and authorizes me to receive Program product for the identified patient.
5. That the completed prescription provided with this request was completed and signed by me, and that I have made an independent medical judgment that the prescription is in the best clinical interest of the identified patient.

Practitioner Signature:	**Date:**

(Signature of Prescribing Practitioner above) Original signature only - stamps ARE NOT acceptable.

Patient First Name (print):	**Patient Last Initial:**

I verify that all information provided in this request is complete and accurate. I certify that I am either uninsured or I do not have insurance or any other coverage (including any government-funded program benefits, such as Medicaid and Medicare) for the requested medication. If I am enrolled in Medicare Part D, I certify that I will not seek to count any product that I receive through the Program towards my TrOOP. I further certify that I meet the financial need criteria specified above. I understand I am expected to seek any available state or government assistance before applying to the Program. I agree that I will not submit any claim for reimbursement for any of the products that I receive from the Program from any public or private third party payor. I understand that Bausch & Lomb reserves the right at any time and without notice to modify this application form or modify or discontinue the Program and the related eligibility criteria. I authorize the use of this information on this application to process my request.

Patient Initial Signature:	**Date:**

Original signature only - copies ARE NOT acceptable

The following medications are available from the Bausch & Lomb Patient Assistance Program. A maximum of one (1) bottle of any one product may be specified on any one request. Any request above the specified limit will not be shipped. No substitutions are allowed. Please allow 4-6 weeks for delivery. Please check appropriate medication below:

Alrex® (loteprednol etabonate ophthalmic suspension 0.2%) 10 mL	**Qty (max 1):**_____
Besivance® (besifloxacin ophthalmic suspension) 0.6% 5 mL	**Qty (max 1):**_____
Lotemax® (loteprednol etabonate ophthalmic suspension 0.5%) 10 mL	**Qty (max 1):**_____
Zylet® (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension) 10 mL	**Qty (max 1):**_____
Zirgan® (ganciclovir ophthalmic gel) 0.15% 5 gm	**Qty (max 1):**_____
Bromday® (bromfenac ophthalmic solution 0.09%) 1.7 mL	**Qty (max 1):**_____
Bepreve® (bepotastine besilate ophthalmic solution 1.5%) 10 mL	**Qty (max 1):**_____