**PATIENT ASSISTANCE PROGRAM**

PO BOX 42847 CINCINNATI, OH 45242 | PHONE: (800) 553-6783 | FAX: (513) 618-0054

# FAX TRANSMITTAL SHEET

**Attn:** ______________________ **From:** ______________________

**Fax:** ______________________ **Date:** ______________________

**Phone:** ______________________ **Number of pages including cover:** __________

**Re:** ______________________ **Re Patient:** ______________________

## PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application **MUST** be filled out in its entirety.
- **FAX** or **MAIL** completed application with income documentation to the address above.
- Healthcare Provider and Patient **MUST** sign the application.
- Patient **MUST** provide a Social Security Number.
- Patients at or below 200% of the current Federal Poverty Level are eligible for assistance.
- A six month supply of the medication(s) requested will ship to the Healthcare Provider's office.*
  - *A three month supply of Restasis is provided.
- A copy of the original application can be faxed or mailed to the address above.

## REORDER INSTRUCTIONS

- The application is valid for one year. A copy of the application signed by the Healthcare Provider can be mailed or faxed to reorder. Patient may re-apply as early as one month in advance.
- Patient Income Verification is valid for three years.

## PATIENT INCOME VERIFICATION

- Patient **MUST** attach a copy of their most recent household income verification.

  Acceptable forms of documentation include:
  - Copy of most recent U.S. Income Tax Return, IRS Form 1040, 1040A, 1040EZ, 1040 NR or 1040 PR
  - Copy of most recent Social Security/Disability Award Letter, Benefit Statement, or monthly check.
  - Copy of most recent pay stub
- If the patient is unable to provide documentation of their income, the Healthcare Provider may attest to the patient's need by signing the "Income Verification" section on the bottom of the application.

**PLEASE NOTE:** Healthcare Providers can manage the patient assistance application process on-line at **www.RxHope.com/Allergan**

Rev 09/24/09

# PATIENT ASSISTANCE PROGRAM

PO BOX 42847 CINCINNATI, OH 45242 | PHONE: (800) 553-6783 | FAX: (513) 618-0054

## PHYSICIAN INFORMATION

State License #____________________________ Exp. ____________ TPA# (ODs Only) ______________________

Physician Name (First, MI, Last) ______________________________________________ Designation __________

Address ____________________________________________________________________________________________

City ____________________________ State ________ Zip Code ____________ Email _____________________

Telephone _______________________ Fax ______________________ Office Contact ______________________

*I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.*

**PHYSICIAN SIGNATURE:** __________________________________________________ **DATE** _______________

## PRODUCT INFORMATION

- ☐ **ACZONE® Gel 5%** (dapsone) 30g, 3 tubes
- ☐ **ACUVAIL™ 0.45%** (ketorolac tromethamine ophthalmic solution) 30x.4mL, 2 boxes
- ☐ **ALPHAGAN® P 0.1%** (brimonidine tartrate ophthalmic solution) 15 mL, 3 bottles
- ☐ **COMBIGAN® 0.2%/0.5%** (brimonidine tartrate/timolol maleate ophthalmic solution) 10 mL, 3 bottles
- ☐ **LUMIGAN® 0.01%** (bimatoprost ophthalmic solution) 7.5 mL, 2 bottles
- ☐ **PRED FORTE® 1.0%** (prednisolone acetate ophthalmic suspension) 5 mL, 2 bottles
- ☐ **PRED FORTE® 1.0%** (prednisolone acetate ophthalmic suspension) 10 mL, 2 bottles
- ☐ **RESTASIS® 0.05%** (cyclosporine ophthalmic emulsion) 30x.4 mL, 6 trays
- ☐ **SANCTURA XR™ 60 mg tablets** (trospium chloride extended-release tablets) 6 each
- ☐ **TAZORAC® Gel 0.05%** (tazarotene) 100g, 3 each
- ☐ **TAZORAC® Gel 0.1%** (tazarotene) 100g, 3 each
- ☐ **TAZORAC® Cream 0.05%** (tazarotene) 60g, 5 each
- ☐ **TAZORAC® Cream 0.1%** (tazarotene) 60g, 5 each

## PATIENT INFORMATION

Patient Name (First, MI, Last) _________________________________ Date of Birth (MM/YYYY) _____________

Social Security Number ______________________________ Telephone ___________________________________

Number of Persons in Household ________ Gross Annual Household Income $___________________________

Patient must attach a copy of their most recent household income verification.

## INSURANCE INFORMATION

Is the patient enrolled in any of the following insurance programs? (Circle YES or NO for each question)

Private Insurance: Yes / No     Medicare: Yes / No     If Other, please specify:

Medicaid: Yes / No     Medicare Part D: Yes / No     _______________________________

If so, is the medication requested covered at all through any of the above selected programs? ☐ Yes ☐ No

*I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of the program. I hereby authorize the patient assistance program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.*

**PATIENT SIGNATURE:** ______________________________________________________ **DATE** ________________

## FOR PHYSICIANS ONLY: INCOME VERIFICATION

PHYSICIAN MAY SIGN BELOW ***to verify that the patient meets the Federal Poverty Guidelines as stated, but is unable to provide documentation of their income.****

**INCOME VERIFICATION:** ___________________________________________________________ **DATE** _________________

*SEE ATTACHED INSTRUCTION SHEET

ALLERGAN ©2009 Allergan, Inc., Irvine, CA 92612 ® and ™ marks owned by Allergan, Inc.

Aczone is manufactured by Tolmar
Sanctura is manufactured by Catalent Pharma Solutions