



Alaven Patient Assistance Program
PO Box 5836 ~Somerset, NJ 08875
Phone: (800) 593-7923 ~ Fax: (732) 507-7624

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application **MUST** be filled out in its entirety.
- 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.
- For Anadrol-50 a 30 day supply will be shipped the Healthcare Provider's DEA Address where subject to Federal and State Law.
- FAX or MAIL completed application with income documentation to the address above.

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, 1040NR 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 attaching a letter stating that patient has no income and is unable to afford the requested medication.

DENIAL AND APPEAL REQUIREMENTS

Income Appeals:

Acceptable documentation includes year-to-date pharmacy printout or Explanation of Benefits (EOB) from the insurance provider and/or documentation of other medical expenses.

Private Insurance or Medicaid Coverage Appeals:

Partially Covered: Acceptable documentation includes year-to-date pharmacy printout or Explanation of Benefits (EOB) from insurance provider and/or documentation of other medical expenses.

Not Covered: Patient must submit documentation that the medication is not covered. Acceptable documentation includes a denial of prior authorization from the insurance carrier or a pharmacy claim denial.

Medicare Part D Coverage Appeals:

Acceptable documentation includes year-to-date pharmacy printout or Explanation of Benefits (EOB) from the insurance provider and/or documentation of other medical expenses.

All appeals are reviewed by the RxHope Program Manager on a case-by-case basis.

PLEASE NOTE : Healthcare Providers and Patients can initiate the application process on-line at www.RxHope.com/Alaven



Alaven Assistance Program
P.O. Box 5836 - Somerset, NJ 08875
Phone: 800-593-7923 - Fax: 732-507-7624
Email: alaven@rxhope.com

Physicians can apply online at www.RxHope.com

■ PHYSICIAN INFORMATION

Physician Name (Last, First, MI) _____ Designation _____

DEA # (Required)* _____ State License # _____ Exp _____

DEA Address _____

City _____ State _____ Zip Code _____ Email _____

Telephone _____ Fax _____ 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 _____

***Medication must be shipped to DEA Address**

■ PRODUCT INFORMATION



Please Attach a Prescription for Anadrol

Please indicate number of tablets per day:

___ 1 ___ 2 ___ 3 Refills: ___

- 50mg tablets

- A 30-day supply is provided



Please indicate supply amount:

4-Weeks of Therapy

8-Weeks of Therapy

■ PATIENT INFORMATION

Patient First Name _____ MI _____ Last Name _____

Address _____ City _____

State _____ Zip _____ Marital Status: S M D W Other

Telephone _____ Date of Birth (MM/DD/YYYY) _____ Male Female

Social Security # _____ Are you a U.S. Resident? Y N Are you a Veteran? Y N

Number of Persons in Household _____ Household Gross Income* \$ _____

*Documentation Required. See Instructions Sheet for Acceptable Proof of Income Documentation

Do you have Prescription Drug Coverage? Yes No Are you enrolled in Medicaid? Yes No

Are you enrolled in Medicare Part D? 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 _____

Fax completed application to 732-507-7624 or Mail to the address above