



PATIENT ASSISTANCE PROGRAM

PO BOX 6623 SOMERSET, NJ 08875 | PHONE: (800) 553-6783 | FAX: (732) 507-7636

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



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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

- | | |
|--|---|
| <input type="checkbox"/> ACZONE® Gel 5%
(dapson) 30g, 3 tubes | <input type="checkbox"/> PRED FORTE® 1.0%
(prednisolone acetate ophthalmic suspension) 10 mL, 2 bottles |
| <input type="checkbox"/> ACUVAIL™ 0.45%
(ketorolac tromethamine ophthalmic solution) 30x.4mL, 2 boxes | <input type="checkbox"/> RESTASIS® 0.05%
(cyclosporine ophthalmic emulsion) 30x.4 mL, 6 trays |
| <input type="checkbox"/> ALPHAGAN® P 0.1%
(brimonidine tartrate ophthalmic solution) 15 mL, 3 bottles | <input type="checkbox"/> SANCTURA XR™ 60 mg tablets
(trospium chloride extended-release tablets) 6 each |
| <input type="checkbox"/> COMBIGAN® 0.2%/0.5%
(brimonidine tartrate/timolol maleate ophthalmic solution) 10 mL, 3 bottles | <input type="checkbox"/> TAZORAC® Gel 0.05%
(tazarotene) 100g, 3 each |
| <input type="checkbox"/> LUMIGAN® 0.03%
(bimatoprost ophthalmic solution) 7.5 mL, 2 bottles | <input type="checkbox"/> TAZORAC® Gel 0.1%
(tazarotene) 100g, 3 each |
| <input type="checkbox"/> PRED FORTE® 1.0%
(prednisolone acetate ophthalmic suspension) 5 mL, 2 bottles | <input type="checkbox"/> TAZORAC® Cream 0.05%
(tazarotene) 60g, 5 each |
| | <input type="checkbox"/> 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