

Aricept Patient Assistance Program

**P.O. Box 679
Somerville, NJ 08876
Phone (800) 226-2072
Fax (800) 226-2059**



General Program Information

- Once you qualify, you may be able to receive free medication for up to 12 months.
- Up to a 90 day supply of medication will be sent to your healthcare practitioner.
- Re-enrollment is required after one year.

Instructions for Initial Enrollment and Refills

- The patient section must be completed and signed.
- The practitioner section must be completed and signed (no signature stamps, please)
- The practitioner must complete the Prescription Information section on the application form or include an original prescription written for a 90 day supply of the name brand medication along with formulation.
- Attach a copy of the patient's most recent Federal tax return. If the patient does not file taxes please include other proof of annual household income (ie: W-2, 1099 social security, disability or pension statement, unemployment award letter, etc. for everyone in the household.) If the patient has \$0 household income, please attach a letter signed by the practitioner or patient advocate verifying their claim.
- Fax the completed application, prescription (if not using the Prescription Information section on the form) and the patient's proof of income to (800) 226-2059 or mail to: Aricept Patient Assistance Program P.O. Box 679 Somerville, NJ 08876
- Refills are available by submitting a completed application form with a new 90 day prescription written for the brand name medication including formulation.

Patient Assistance Program Eligibility

- Patient must be a resident of the United States.
- Patient cannot have any government prescription coverage such as Medicaid, Veteran's Administration, or any state or local programs.
- Patient cannot have any private prescription drug coverage.
- Patient must meet an income threshold, determined by household size.

Please note:

The Aricept Patient Assistance Program reserves the right to modify or discontinue this program at any time, with or without notice.

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**PATIENT SECTION**

First Name:	MI:	Last Name:
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone Number:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>

PATIENT ELIGIBILITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

Medicaid	Yes <input type="checkbox"/>	No <input type="checkbox"/>	State/Local Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medicare Part D	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Veteran's Administration	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Private (HMO/PPO)	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Are you in the Medicare Part D Coverage Gap? ("donut hole"): Yes <input type="checkbox"/> No <input type="checkbox"/>					
Are you a U.S. Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>			Social Security Number: _____ - _____ - _____		
What is your total ANNUAL Household Income? (Including Social Security, Pension income, etc.): \$ _____					
How many people, including the patient, live in your household? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/>					

Patient Certification and Authorization to Disclose Information

Patient Name: _____ I verify that the information provided in this application is complete and accurate. I understand that Eisai reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the Aricept Patient Assistance Program. If I choose to enroll into Medicare D, I will not submit any claim for reimbursement to any third party, including my Medicare Part D Plan, for any medications provided to me through the Aricept Patient Assistance Program. I will not claim true-out-of-pocket cost ("TrOOP") from my Medicare Part D Plan for the value of any medications provided to me through the Aricept Patient Assistance Program. I authorize Eisai/Pfizer and their authorized agent(s) to use the information on this application to process my request for medication from the Aricept Patient Assistance Program and authorize the use of my Social Security number for identification purposes and record keeping. I further authorize Eisai to use the information contained on this form to contact me or my healthcare provider to review my eligibility for the program, and to confirm receipt of medications. I agree that I will contact the Aricept Patient Assistance Program if any of the information regarding prescription drug coverage or insurance changes. I understand that I may revoke this consent and withdraw from participation in the program at any time by calling (800)226-2072. I understand that my prescribing physician is responsible for choosing which prescription products are right for me, and that Eisai is not responsible for verifying my medical condition or my prescribing physician's selection of products.

Patient Signature: _____

Date: _____

LICENSED PRACTITIONER SECTION

Name:	Professional Designation:	
Office Address: (No P.O. Box)		
City	State	Zip Code:
DEA / State License#:	Contact Person:	
Office Phone Number:	Office Fax Number:	

PRESCRIPTION INFORMATION

Product Name: ARICEPT	Strength:	Quantity Per Day:
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I certify that the information provided in this application is complete and accurate to the best of my knowledge, that the product ordered hereunder is medically indicated for this patient, and that I will be supervising the patient's treatment. I understand and certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party (including, but not limited to, Medicare and any other governmental programs) shall be charged for such product. Additionally, no units of this product will be submitted for Medicare, Medicaid, or any public or private third party reimbursement, or returned for credit. I understand eligibility under this program is subject to Eisai's approval and the patient's continuing compliance with all eligibility requirements, as set by Eisai from time to time. I agree to allow Eisai, or its authorized agent(s), to review the medical, financial, and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the program and the patient's receipt of any product(s) provided to him or her through the program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient.

Healthcare Provider Signature: _____

Date: _____

(no signature stamps, please)