



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

To apply for the Aricept Patient Assistance Program, please complete and sign this application, and mail or fax to the address or number listed above. Include the appropriate income documentation listed below. Incomplete applications will cause a delay in processing, so if you need assistance filling out this application, please contact the Aricept PAP at (800) 226-2072.

**Patient Section\* – The patient or his/her legal guardian must complete this section.**

NAME:	SOCIAL SECURITY#:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	GENDER: M or F	Marital Status: Single / Married
PHONE NUMBER:		
DOES THE PATIENT HAVE OR QUALIFY FOR PRESCRIPTION COVERAGE IN ANY GOVERNMENT PROGRAMS? <i>(This includes Medicare, Medicaid, Veteran's Administration and any other state or local programs.)</i> YES <input type="checkbox"/> NO <input type="checkbox"/>		
DOES THE PATIENT HAVE MEDICARE PART D PRESCRIPTION COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>		
NAME OF INSURANCE: _____ POLICY # _____		
Does the patient qualify for Medicare? Yes / No		
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE IN ANY PRIVATE PROGRAMS? <i>(This includes coverage through any private insurance, HMOs, or PPOs.)</i> YES <input type="checkbox"/> NO <input type="checkbox"/>		
IS THE PATIENT A LEGAL U.S. RESIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Total Monthly Household Income—Proof of income from all sources must be attached (see below for details)		
Salary/Wages:		
Social Security:		
Social Security Supplemental:		
Disability:		
Unemployment Compensation:		
Pension:		
Investment Income:		
Total:		
Proof of Income Requirements		
The following information and documentation must be included when submitting this application for consideration into the Aricept Patient Assistance Program:		
If you are a participant in the Medicare Part D program, you must provide a photo copy of your Medicare card (front/back).		
Proof of monthly income for all persons in the household must be attached. Acceptable documents are:		

-Monthly pay stubs (current within the last two months)

-Yearly benefits (Social Security, etc.) can be award letter, benefit statement, or bank statements showing automatic deposit for the current calendar year

-Self-employed patients must attach a copy of most current Federal Income Tax form with appropriate schedules

-If you have no income, you must attach a note from your physician or social worker on their letterhead stating to the best of their knowledge that you have no income

Patient's or Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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's or Legal Guardian's Signature

Date

**Licensed Practitioner Section\* - The licensed practitioner must complete this section.**

Prescriber's NAME:

Facility Name:

PROFESSIONAL DESIGNATION: (MD, DO, ETC.)

OFFICE ADDRESS: (No P.O. Box)

CITY:

STATE:

ZIP CODE:

DEA and /State License#

To the best of your knowledge, does the patient have prescription drug coverage? Yes No

CONTACT PERSON IN OFFICE:

OFFICE PHONE and fax #s:

Please check this box if you wish to receive the standard formulation of Aricept. Otherwise all requests will be filled with Aricept ODT.

This section of the form will serve

as the prescription:

Quantity: 90 tablets  
(1 bottle of 90 tablets)

- 5mg  
 10mg

Sig: \_\_\_\_\_

**PHYSICIAN'S/PRESCRIBER'S ATTESTATION:**

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.

Original Signature of Prescriber

Date

\*IF ALL INFORMATION IS NOT CLEARLY AND COMPLETELY FILLED OUT, THIS FORM WILL NOT BE PROCESSED