

Ascend Therapeutics Patient Assistance Program Application EstroGel® 0.06% (estradiol gel)

Thank you for your request for information regarding the Ascend Therapeutics Patient Assistance Program. The program makes EstroGel® available free of charge to legal U.S. residents who meet certain financial guidelines. The enclosed application must be filled out completely and signed by a licensed practitioner (an MD or DO, or a Nurse Practitioner or Physician Assistant in those states where NPs and PAs are authorized to write prescriptions).

The completed application must be submitted **directly from the licensed practitioner's office by mail** to the address listed below.

- The form must be typed or completed in ink with an original signature from the licensed practitioner (no stamped or photocopied signatures accepted).
- The patient must be a legal U.S. resident.
- The patient's household income must fit within certain financial criteria. This is determined by comparing an equation of the patient's annual household income to published federal poverty guidelines.
- Attach copies of financial documentation for proof of patient's income. Do not send original documents. Some examples of acceptable financial documentation are 1040, 1040EZ and 1099 tax forms. If no income reported, please submit a letter of hardship from a social worker or a copy of a social security check.

If the application is approved, a voucher good for 12 months of therapy will be sent via USPS directly to the requesting patient at the shipping address indicated on the application.

SECTION A - HEALTH CARE PROVIDER INFORMATION

Date: _____ Health Care Provider's full name: _____

State License Number: _____ Telephone Number: _____

SECTION B - PATIENT INFORMATION

Name: _____ Telephone Number: _____

Date of Birth: _____ Male Female Is the patient a U.S. resident? Yes No

Social Security No.: _____ - _____ - _____ (required)

Shipping Address: _____

PATIENT INSURANCE INFORMATION

Private Insurance	Medicare	Medicaid	Prescription Drug Coverage for Requested Medication
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

of People in Household: _____ Annual Household Income: _____ Patient's Annual Out-of-Pocket Medical Costs:* _____

* (E.g., prescription or over-the-counter medication costs, hospital and physician bills, etc. actually paid by the patient or other financially responsible individual in the same household. If medical costs exceed \$500 per month, please submit documentation of expenses.)

I certify that all of the above statements and information provided are correct. I understand that continued eligibility under this program is subject to Ascend Therapeutics, Inc., approval.

Patient Signature: _____

SECTION C - SIGNATURE

If this application is approved, a multiple-use voucher good for twelve EstroGel® 0.06% (estradiol gel) 50g pumps will be sent to the patient. Each pump contains a one-month supply and will be distributed one at a time. The patient can reapply to the program once the voucher has been used twelve times.

I certify that all of the above statements and information provided are correct. I understand that continued eligibility under this program is subject to Ascend Therapeutics, Inc., approval.

Health Care Provider's Original Signature: _____

(No stamps or photocopied signatures are acceptable.)

Mail completed forms and financial documentation to: Ascend Therapeutics, Inc., c/o Triple i, P.O. Box 2092, Morrisville, PA 19067-9608.