



BTA Patient Assistance Program Application

Products Available:

Zovirax cream: 2 gram tube

Zovirax ointment: 15 gram tube

Enrollment Instructions:

- Complete and sign Patient Section (original signatures only, NO PHOTOCOPIES).
- Complete and sign Practitioner Section (original signatures only, NO PHOTOCOPIES).
- Attach a copy of the patient's most recent Federal tax return.
 - If the patient does not file a Federal tax return, please attach other proof of annual household income (ie: W-2, 1099, social security, disability or pension statement, unemployment award letter, etc.). **Paystubs are not acceptable as proof of income.** If the patient has \$0 household income, please attach a letter from the doctor or patient advocate verifying their claim.
- Attach an original brand name prescription for a 3-month supply of medication.
- Mail original application, original prescription, and proof of income to:

**BTA Patient Assistance Program
P.O. Box 836
Somerville, NJ 08876**

- Please allow 2 to 4 weeks to approve your application and receive product at your practitioner's office.
- Both the patient and practitioner will be advised in writing of any denied requests.
- Incomplete applications will not be processed. They will be returned to either the patient or practitioner for completion.

Refill Instructions:

- Complete and sign Patient Section (original signatures only, NO PHOTOCOPIES).
- Complete and sign Practitioner Section (original signatures only, NO PHOTOCOPIES).
- Attach an original brand name prescription for a 3-month supply of medication.
- Mail original application, original prescription, and proof of income to the address above.

Program Eligibility:

- Patient must be a legal resident of the United States.
- Patient cannot have or qualify for any government prescription coverage such as Medicaid, Veteran's Administration or any state or local programs.
- Patient cannot have any private prescription coverage such as an HMO or PPO plan.
- Patient cannot be enrolled in Medicare Part D.
- Patient's total annual household income must be at or below the program income maximum based on household size. (See chart below)

Household Size	Total Annual Household Income *
1	\$27,075
2	\$36,425
3	\$45,775
4	\$55,125
5	\$64,475
6+	\$73,825

* Income totals are approximate and are subject to change.

Please note: BTA Pharmaceuticals Inc. will make every effort to grant aid when needed. This program is limited to available resources and may be revised or discontinued at any time.



*IF ALL INFORMATION IS NOT COMPLETE AND LEGIBLE, THIS FORM WILL NOT BE PROCESSED.

BTA Patient Assistance Program
P.O. Box 836
Somerville, NJ 08876
(866) 268-7325

WELLBUTRIN XL PATIENT ID

Patient Section * The patient or his/her guardian must complete and sign this section.
NAME: SS#
ADDRESS:
CITY: STATE: ZIP CODE:
DATE OF BIRTH: PHONE NUMBER:
Does the patient have or qualify for prescription coverage in any government programs?
Yes [] No []
(This includes Medicaid, Veteran's Administration and any other state or local program.)
Is the patient enrolled in Medicare Part D?
Yes [] No []
Does the patient have prescription coverage in any private program?
Yes [] No []
(This includes coverage through any private insurance plans, HMOs, or PPOs.)
Is the patient a legal U.S. resident? Yes [] No []
What is your total ANNUAL household income (please include wages, social security, disability, unemployment benefits, etc. for everyone living in the home \$ per year
How many people are there in your household? Please circle: 1 2 3 4 5 6+

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for medication. I authorize BTA Pharmaceuticals, Inc. and its agents to use my personal identifying information for the purpose of my participating in the BTA Pharmaceutical Patient Assistance Program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I understand that BTA Pharmaceuticals, Inc. 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 BTA Pharmaceuticals, Inc. BTA Pharmaceutical Patient Assistance Program is authorized to use my Social Security number for identification purposes and record keeping only.

Original Signature of Patient or Legal Guardian (No photocopies)

Date

Licensed Practitioner Section * The prescribing practitioner must complete and sign this section.
NAME:
PROFESSIONAL DESIGNATION (MD, DO, ECT.):
OFFICE ADDRESS: (No. P.O. Boxes)
CITY: STATE: ZIP CODE:
DEA#: (If you do not have a DEA#, please attach a copy of your state license)
CONTACT PERSON IN OFFICE:
OFFICE PHONE #: OFFICE FAX #:

I verify that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I have read, understand and agree to all of the above. I attest that I am not on the HHS/OIG list of Excluded Individuals. I understand that BTA Pharmaceuticals, Inc. reserves the right to modify or terminate this program at any time. My signature certifies that goods received from BTA Pharmaceuticals, Inc. are for the use of the above patient only. These goods will not be sold nor offered for sales, trade or barter and will not be returned for credit. I understand that BTA Pharmaceuticals, Inc. reserves the right to recall the product when necessary.

Original Signature of Licensed Practitioner (No stamped signatures or photocopies)

Date

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