



Cesamet® Patient Assistance Program Application Instruction Sheet

P.O. Box 4008 Clinton, NJ 08809 Phone: 1-800-593-6910 Fax: 1-732-507-7614

Healthcare Providers can apply online at www.RxHope.com/Cesamet, and by phone or fax.

Eligibility Requirements

- The patient must not have prescription drug coverage through any third party medicare, medicaid, or any other state or federal program.
- Application must be signed by both healthcare provider and patient.
- The patient must be a U.S. resident.
- The patient must include an original prescription with the completed application.*
- Patient's income must be below 250% of the U.S. Federal Poverty Level.

Family Size:

1 - \$25,525	5 - \$60,325
2 - \$34,225	6 - \$69,025
3 - \$42,925	7 - \$77,725
4 - \$51,625	8 - \$86,425

* If the application is faxed, please also mail the original prescription.

Patient Income Verification

Patient **MUST** attach a copy of their most recent household income verification.

Acceptable forms of documentation include one of the most recent:

- U.S. Income Tax Return
- W-2 Statement
- IRS Form 1040
- Social Security Benefit Statement
- Disability Statement
- Pay stub

Application must be filled out in its entirety.

FAX or MAIL completed application with income documentation to the address above.



Cesamet Patient Assistance Program
P.O. Box 4008 • Clinton, NJ 08809
Phone: 1-800-593-6910 • Fax: 1-732-507-7614
www.RxHope.com/Cesamet

Clinical Trial Patient? Y N

Patient Information

Patient Name (First, MI, Last) _____

Address _____

City _____ State _____ Zip Code _____ Marital Status: S M D W

Phone _____ Date of Birth (MM/DD/YYYY) _____ Sex: M F

Social Security # _____ Are you a U.S. resident? Y N Are you a Veteran? Y N

Number of persons in household _____ Gross Annual Household Income \$ _____

Do you have any prescription coverage for the medication prescribed? Y N _____

Are you enrolled in Medicare Part D? Y N

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 this program. I hereby authorize the Cesamet 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 _____

Physician Information

DEA Number _____ State License Number _____ Exp _____

Physician Name (First, MI, Last) _____

Address _____

City _____ State _____ Zip Code _____ Contact _____

Telephone _____ Fax _____ Email _____

I verify that the information provided in this application 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



_____ 1 mg capsule(s) _____ time(s) per day

Fax completed application to 732-507-7614 or mail to the address above.