



ECR Pharmaceuticals' Patient Assistance Application Form

Products Covered (Package Size):

- Lodrane 24 (60)
- Lodrane 24D (60)
- Bupap (100)

If the patient is eligible to receive prescription drug assistance under this program:

- *The physician must submit this form to ECR Pharmaceuticals with a signed prescription.*
- *The requested product will be shipped directly to the physician's office. The physician should dispense the product to the patient, providing appropriate dosing instructions.*

Eligibility Guidelines: To be eligible for ECR Patient Assistance Program consideration, the patient must meet all of the following criteria: **(a)** Patient must be a US citizen and cannot have prescription drug coverage or insurance, either private or through any governmental program, **(b)** Patients who are eligible for Medicare Part D or Medicaid drug assistance are not eligible for this program, **(c)** Patients are eligible to receive assistance through this program if their income is at or below 200% of the Federal Poverty Level. (See current income guidelines provided with this application.)

All information provided in this application will be treated with strict confidentiality. Please note that this application must be fully completed and signed by both the patient and an appropriately licensed physician or healthcare professional. A separate application form is required each time a product is requested.

Patient Information

(To be completed by Patient or Patient's Guardian)

First Name _____ Middle Initial _____ Last Name _____

Street Address (No P.O. Box Number)

City _____ State _____ Zip _____

Telephone (____) _____ SSN _____

Date of Birth (m/d/yr) ____ / ____ / ____ Sex: Male ____ Female ____

Name of individual completing this form if other than patient:

Relationship to patient: _____

Patient Certification :

I certify that the information provided in this application is complete and accurate. I understand that the firm sponsoring this assistance program may request documentation that I meet the eligibility requirements as outlined above in order to receive prescription drug assistance under this program. ECR reserves the right to modify or discontinue any or all patient assistance programs without notice.

X _____ Date ____ / ____ / ____
Patient's Signature (or Legal Guardian)

Physician Certification :

By requesting prescription drug assistance for the patient listed above, I certify that it is my belief that my patient meets the eligibility guidelines of this program.

X _____ Date ____ / ____ / ____
Physician's Signature (**REQUIRED**)

X _____ Physician's Phone Number(**REQUIRED**) _____ Physician's DEA or License# (**REQUIRED**)

A fully completed prescription on the requesting physician's prescription pad must be attached.

In addition to the patient and product information, this prescription must contain the physician's name, office address to which the product will be shipped, and the physician's DEA or state license number. The prescription must be signed by the physician. Products will be provided in the commercial package sizes listed above under Products Covered.

**This application and the accompanying prescription should be mailed to:
ECR Patient Assistance, PO Box 71600, Richmond, VA 23255,
OR Faxed to ECR Patient Assistance, (804) 527-1959.**

**ECR Pharmaceuticals
Richmond, Virginia (804) 527-1950**