



Mail the application, financial documentation, copy of federal or state ID, and prescription to:  
**Endo Patient Assistance Program**  
 P.O. Box 66761  
 St. Louis, MO 63166-6761

**Questions – Please call 1-866-824-4747**

**IMPORTANT - PLEASE COMPLETE THIS APPLICATION AND FOLLOW THE INSTRUCTIONS BELOW :**

1. Enclose a valid prescription (not to exceed 30 day supply).
2. Attach copy of a federal or state ID.
3. Attach Proof of Income (Examples include IRS Form 1040, 1040EZ, 1040X, 8453, 8879, 4506T, 1099, 1099R, 1099RR, social security or disability statement, etc.)

**Section 1 - Physician Information**

Physician Name	DEA	Phone: ( )	
		Fax: ( )	
Address:	City:	State:	Zip:

**Physician/Prescriber Attestation:** To the best of my knowledge, this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature (original signature):	Date:
---	-------

**Section 2 - Patient Information**

Patient Name:	SS#: - -		
Street Address (No P.O. Box):	Date of Birth: / /	Male <input type="checkbox"/>	
		Female <input type="checkbox"/>	
City	State	Zip	Phone ( )
Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 other	U.S. Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you a Veteran of the US Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

**Allergies:**  Yes  No If Yes, please list:

**Current Medications Taking:**

**Current Medical Conditions:**

**Financial Information Note: Please attach Proof of Income (Examples include IRS Form 1040, 1040EZ, 1040X, 8453, 8879, 4506T, 1099, 1099R, 1099RR, social security or disability statement, etc.)**

**List All Sources, Gross Monthly Amounts**

Salary/Wages \$ _____	Social Security \$ _____	Alimony/Child Support \$ _____
Disability \$ _____	Pension/Retirement \$ _____	Unemployment/Workers Comp \$ _____

**Total Gross Household Monthly Income: \$ \_\_\_\_\_**

**Total Patient Assets: \$ \_\_\_\_\_** (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Insurance Information	Check one	Insurance Information	Check one
Private Prescription Drug Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid –	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, do you have QMB coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford 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 understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this Application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize the program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application. Endo, Inc. is not responsible for verifying any of the information contained in Section 2 above, including medical conditions, allergies, or other medications that I am taking.

Patient's Signature (original signature):	Date:
---	-------