



**P.O. Box 66761
St. Louis, MO 63166-6761**

Dear Patient or Health Care Provider:

Thank you for your interest in the Endo Pharmaceuticals Patient Assistance Program. To be eligible for the Endo Patient Assistance Program, a patient must be a **Legal U.S. Resident**, meet specific **income requirements**, and must **not have prescription drug coverage** from an insurance provider. To avoid delay, please use the enclosed application. Please complete the following steps to apply for the Endo Pharmaceuticals Patient Assistance Program.

1. Complete all patient and physician sections of the attached application; both patient and physician must sign the application.
2. Include a separate prescription or complete prescription section on the application.
3. Attach a copy of the patient's most recent year federal tax return or financial documentation (examples include: IRS Form 1040, 1040EZ, 4506T, 1099, Social Security or Disability statement).
4. Mail the application and financial documentation to:

**ENDO PATIENT ASSISTANCE PROGRAM
PO BOX 66761
ST. LOUIS, MO 63166-6761**

Or fax the application and financial documentation to 1-800-889-0353.

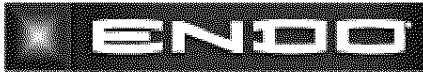
We will review and process the patient's eligibility once we receive the completed application and financial documentation. You will receive written notification concerning the patient's eligibility within 5-7 business days.

If you have any questions, please call an Endo Pharmaceuticals Patient Assistance Program representative at 1-866-824-4747, Monday through Friday, 8:00 am to 5:00 pm CST.

Sincerely,

Endo Pharmaceuticals Patient Assistance Program

PLEASE CALL 1-866-824-4747 WITH ANY QUESTIONS - FAX # 1-800-889-0353



PHARMACEUTICALS

Mail to: P.O. Box 66761
St. Louis, MO 63166-6761
Fax: 1-800-889-0353

Questions? Call 1-866-824-4747

Enrollment Status:

- New Enrollment
 Re-Enrollment
 Re-Order (please complete sections 1 & 2)

Section 1 - Physician and Prescription Information			
Physician Name:		DEA/State License #:	Phone: ()
			Fax: ()
Address:		City:	State: Zip:
Prescription			
Drug Name & Strength:			
<input type="checkbox"/> Frova 2.5 mg Tablet	Qty	<input type="checkbox"/> 9 tablets	<input type="checkbox"/> 18 tablets (18 tablets is maximum for a 90 day supply)
<input type="checkbox"/> Lidoderm 5% Patch	Qty	<input type="checkbox"/> 30 patches	<input type="checkbox"/> 60 patches <input type="checkbox"/> 90 patches (90 patches is maximum for a 90 day supply)
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:			Date:
Section 2 - Patient Information			
Patient Name:		SS#/green card#:	
Street Address:		Date of Birth:	Male <input type="checkbox"/>
		/ /	Female <input type="checkbox"/>
City	State	Zip	Phone ()
Section 3 - Enrollment Information			
Number of Household members (including self)? (circle one)	Legal U.S. Resident?	Are you a Veteran of the U.S. Armed Forces?	Are you Disabled?
1 2 3 4 5 6 7 other	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Financial Information Note: You must attach copy of your most recent U.S. Income Tax Return, Some examples are: IRS Form 1040, 1040A, 1040EZ, 1040X, 8879, 8453, 4506T, 1099			
List All Sources, Gross Monthly Amounts		Prescription Drug Coverage	
Salary/Wages \$ _____	Unemployment/Work Comp \$ _____	Prescription Drug Coverage	Yes <input type="checkbox"/> No <input type="checkbox"/>
Social Security/Disability \$ _____	Pension/Retirement \$ _____	Medicaid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child Support/ Alimony \$ _____	Social Security \$ _____	QMB Coverage	Yes <input type="checkbox"/> No <input type="checkbox"/>
Total Gross Household Monthly Income: \$ _____ (if you have no income please indicate as N/A in the income total)		Medicare	Yes <input type="checkbox"/> No <input type="checkbox"/>
Total Patient Assets: \$ _____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)			
Section 4 - Patient Signature			
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:			Date: