



FOREST PHARMACEUTICALS, INC.

Patient Assistance Program

13645 Shoreline Drive • Earth City, MO 63045-1241 • (800) 851-0758

FOREST PHARMACEUTICALS, INC. PATIENT ASSISTANCE PROGRAM

The Forest Pharmaceuticals, Inc. Patient Assistance Program (“FPI PAP”) provides medication to qualifying applicants at no charge. If the applicant qualifies under FPI PAP guidelines, a three-month supply of the requested drug(s) or device(s) will be shipped to the applicant’s licensed practitioner for dispensing.

APPLYING TO FPI PAP

Applicant

- The applicant is required to complete sections 1.0, 1.1 and 3.0 on the application. If you are a Medicare Part D enrollee you must also sign and date section 3.1 and have applied for and been denied the Low-Income Subsidy (“LIS”) from the Social Security Administration (“SSA”).
 - The applicant must print his/her legal name exactly as it appears on the Social Security card issued to the applicant.
 - To apply for LIS please contact the SSA at 800-772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/. Attach a photocopy of the LIS denial letter to the FPI PAP application.
 - Please sign and date the certification sections in a color other than black ink. Signature and date are valid for 3 months.

Licensed Practitioner

- The prescribing licensed practitioner is required to complete sections 2.0 and 4.0. In addition the same licensed practitioner must complete and attach a prescription written for a three-month supply of all FPI brand requested drug(s) or device(s). If the preprinted office address on the prescription does not match the delivery/ mailing address on the FPI PAP application form, then the licensed practitioner must also attach letterhead or a business card to verify the delivery/ mailing address on the FPI PAP application form.
 - Please sign and date the certification section in a color other than black ink. Signature and date are valid for 3 months.

DOCUMENTS TO SUBMIT TO FPI PAP

- Application completed by the applicant and prescribing licensed practitioner.
- Original prescription written for a three-month supply of medication from the licensed practitioner who signed the application. The prescription is valid for 3 months.
- Photocopy of applicant’s LIS denial letter (Medicare Part D enrollees only). The date on LIS denial letter is valid for 5 years.

APPLICATION PROCESSING

Please allow 4 weeks for application processing and delivery of medication to the licensed practitioner named on the FPI PAP application form.

- If the applicant is approved, a three-month supply of the drug(s) or device(s) requested will be shipped to the licensed practitioner’s office for dispensing. If you would like notification of the ship date for the requested medication, please supply FPI PAP with your email address in the appropriate space on the application.
- If the applicant is denied, the licensed practitioner and applicant will be notified by mail.
- Incomplete applications will be returned to the applicant or licensed practitioner with instructions for completion.

SUBSEQUENT MEDICATION SUPPLIES

Each time a qualifying applicant requires a three month supply of FPI medication, a new FPI PAP application form with original signature, original prescription and photo copy of the LIS denial letter (Medicare Part D enrollees), must be submitted by mail to FPI PAP. You may make photocopies of the blank FPI PAP application form for future use of the FPI PAP.

NO FEES APPLY TO THIS PROGRAM

**The following brand products are available on Forest
Pharmaceuticals, Inc. Patient Assistance Program.**

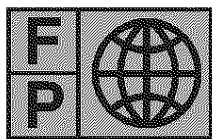
<u>MEDICATION</u>	<u>STRENGTH</u>	<u>SIZE</u>
* Aerochamber® Plus	NA	NA
* Aerochamber® Plus w/Mask	NA	Sm, Reg, Lg
Armour® Thyroid Tablets	¼, ½, 1, 1½, 2, 3, 4, 5 gr	100 ct. bottle
Bystolic® Tablets	2.5, 5, 10, 20 mg	100 ct. bottle
Campral® Tablets	333 mg	180 ct. bottle
Celexa® Tablets	10, 20, 40 mg	100 ct. bottle
Daliresp® Tablets	500 mcg	30 ct. bottle
Levothroid® Tablets	25, 50, 75, 88, 100, 112, 125, 137, 150, 175, 200, 300 mcg	100 ct. bottle
Lexapro® Tablets	5, 10, 20 mg	100 ct. bottle
Lexapro® Oral Solution	5mg = 5ml	8 oz. bottle
Namenda® Tablets	5, 10 mg	60 ct. bottle
Namenda® Oral Solution	10mg = 5ml	12 oz. bottle
Namenda® Titration Pak	5 & 10mg combination pack	28-5mg tablets; 21-10mg tablets
Savella® Titration Pak	12.5, 25 & 50 combination pack	5-12.5mg tablets; 8-25mg tablets; 42-50mg tablets
Savella® Tablets	12.5, 25, 50, 100 mg	60 ct. bottle
Tiazac® Capsules	120, 180, 240, 300, 360, 420 mg	90 ct. bottle
Viibryd Titration Pak	10, 20, 40 mg combination pack	7-10mg tablets; 7-20mg tablets; 16-40mg tablets
Viibryd® Tablets	10, 20, 40 mg	30 ct. bottle

* Maximum amount for Aerochamber® or Aerochamber® with Mask is one per applicant in a six-month period.

**Controlled substances and generic products are not
available on Forest Pharmaceuticals, Inc. Patient
Assistance Program.**

← Staple RX behind completed application; additional information behind RX.

Rev. 4/11


FOREST PHARMACEUTICALS, INC. ▪ Patient Assistance Program

 13645 Shoreline Drive • Earth City MO 63045-1241 • (800) 851-0758 • www.forestpharm.com/pap

For FPI Product Information: (800) 678-1605

SECTION 1.0: PATIENT INFORMATION

First Name (Legal):	MI:	Last Name:	Gender:
Phone Number:	Social Security Number:		Date of Birth:
Mailing Address:	Apt. Number:	PO Box:	
City:	State:	Zip Code:	
Marital Status:	E-Mail Address:		
Gross Monthly Household Income:		Number of People in Household (include yourself):	
Do you have prescription coverage/reimbursement at any time during the year ? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you have a Medicare Part D Plan check no here and yes in section 1.1 below.)			
If yes, please provide your insurance name & copay/reimbursements received for the requested medication. _____			

SECTION 1.1: MEDICARE/MEDICAID INFORMATION

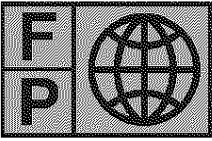
Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you enrolled in Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare ID #: _____	Are you enrolled in a Medicare Part D plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare Part D enrollees: you must have applied for and been denied the Low Income Subsidy ("LIS") from the Social Security Administration ("SSA") before submitting this application to FPI PAP. To apply for LIS please contact the SSA at (800) 772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/. Please attach a photocopy of your LIS denial letter to this application. We are unable to accept a pre-decisional notice.	
Have you attached a photocopy of your Medicare Part D LIS denial letter? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 2.0: LICENSED PRACTITIONER INFORMATION

First Name (Legal):	MI:	Last Name:	Professional Designation:
State License Number:	DEA Number:		
Mailing Address:	Ste. Number:	PO Box:	
City:	State:	Zip Code:	
Delivery Address:	Ste. number:	PO Box:	
City:	State:	Zip Code:	
Office Contact Name:	Phone Number:	Ext:	
Office Contact E-Mail Address:			

 The delivery address for the requested medication is an: Office Clinic

Attach a prescription(s) for a Forest brand product(s) or device(s) to this application.
PATIENT AND LICENSED PRACTITIONER MUST SIGN & DATE THE CERTIFICATIONS ON PAGE 2 OF THE FPI PAP APPLICATION.
FOR FPI PAP USE ONLY
**Audited
By/Date:**
**Entered
By/Date:**
**PAP
Order ID:**
Faxed Applications will not be accepted.



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SECTION 3.0: PATIENT CERTIFICATION

I certify that I do not have the ability to pay for the medication(s) requested by my licensed practitioner on the prescription attached to this application and all information provided in section 1.0 and 1.1 is correct. I understand that Forest Pharmaceuticals, Inc. Patient Assistance Program ("FPI PAP") is entitled at any time to request verification of any such information which I agree to provide. I consent that FPI PAP may contact me for verification of my application status and receipt of the indicated medications(s). I understand that if approved, I am not eligible to seek reimbursement for any medication requested on the prescription attached to this application from any government program or third party insurer. I understand eligibility under the FPI PAP is subject to FPI's discretion and that FPI reserves the right to modify or terminate the PAP at any time.

I authorize my physician to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations there under, "HIPAA", as well as other state or federally protected personal information), to FPI PAP or third parties engaged, as required to assist FPI in administering the FPI PAP. I authorize FPI PAP to disclose my PHI to Centers for Medicare and Medicaid Services ("CMS") for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in FPI PAP with my Medicare Part D plan. I understand that my PHI will consist of my name, address, social security number, income, prescription coverage, prescription for medication, financial documents and insurance records and will be used for purposes of determining my eligibility to participate in FPI PAP and to ship appropriate medication(s) as prescribed by my licensed practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in FPI PAP that I may be notified of such by FPI PAP. I understand that upon the furnishing of my PHI to FPI PAP, my PHI may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I may revoke this authorization at any time by providing written notice to FPI at the address set forth above. My revocation will become effective on the date my written notice is received and processed at FPI PAP.

Patient or Legal Guardian's **ORIGINAL** Signature: (ink other than black and valid for three months)

X

Date: (valid for three months)

X

SECTION 3.1: MEDICARE PART D ENROLLEE CERTIFICATION

I understand that if I am approved for FPI PAP, I will receive a three month supply of medication and that I must re-apply to FPI PAP each time I need medication. I understand that if my application continues to meet the guidelines of FPI PAP I will continue to be approved to receive subsequent three month supplies of medication. I agree that I will not seek the requested FPI medication from my Medicare Part D prescription plan while receiving the medication from FPI PAP. I understand that I am not eligible to seek reimbursement for any medication dispensed by FPI PAP from any government program or third party insurer and will not apply any FPI PAP medication towards True-Out-Of-Pocket ("TrOOP") costs.

Patient or Legal Guardian's **ORIGINAL** Signature: (ink other than black and valid for three months)

X

Date: (valid for three months)

X

SECTION 4.0: LICENSED PRACTITIONER CERTIFICATION

My signature certifies that I am a licensed practitioner eligible under state law, my collaborative agreement and formulary, if applicable, to prescribe, receive and dispense the requested medication(s) listed on this application, shipped from Forest Pharmaceuticals, Inc. I further certify all information provided in section 2.0 and on the attached prescription is correct and agree to submit appropriate verification of such information upon FPI's reasonable request. I agree that medication(s) provided to me by FPI pursuant to prescriptions provided by me for the applicant named in 1.0 will be provided by me to such eligible applicant for his or her own use without charge. I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person. I consent that FPI may contact the applicant named in section 1.0 for verification of applicant status and receipt of the indicated medication(s). I further consent that FPI may perform an on-site audit of PAP records related to the applicant named in 1.0 of this application. I understand that I am not eligible to seek reimbursement for any medication dispensed by FPI PAP from any government program or third party insurer and will not apply any FPI PAP medication towards the applicants TrOOP. I further understand that I cannot seek payment for an office visit from the applicant or third party insurer when FPI PAP medication is provided to the applicant. I also understand that eligibility under the PAP is subject to FPI's discretion and that FPI reserves the right to modify or terminate the PAP at any time.

Licensed Practitioner's **ORIGINAL** Signature: (ink other than black and valid for three months)

X

Date: (valid for three months)

X