

# PATIENT ASSISTANCE PROGRAM ENROLLMENT APPLICATION



Dear Doctor:

Thank you for referring your patient to our Galderma Laboratories Patient Assistance Program. Attached is a copy of the application to be fully and legibly completed and returned with financial documentation for proof of patient income and authorization for disclosure of medical information signed by the patient.

## Instructions

Please complete the application with:

### Practitioner

- Full practitioner information (with mailing address, phone and fax numbers)
- DEA Number **or** State License number **or** National Provider Identifier number
- Practitioner signature
- Rx Information

### Patient

- Full Patient Information (with mailing address and phone number)
- Complete household income Information (with a copy of your most recent tax return)
- Patient signature

**We will accept completed enrollment forms only. Incomplete or incorrect applications will delay the process. Therefore, please ensure all information is correctly provided.**

## Eligibility

- Patient must be a legal resident of the United States
- Patient must not qualify/or must not be eligible for any private insurance prescription coverage such as an HMO or PPO
- Patient must not be enrolled in Medicare Part D, and must not qualify to any state /federal assistance with his prescription medications
- Patient total household income must be below the eligibility standards listed on the chart below:

Household size	Total Annual Household Income	Total Monthly Household Income
1	\$21,660.00	\$1,805
2	\$29,140.00	\$2,428
3	\$36,620.00	\$3,051
4	\$44,100.00	\$3,675
5	\$51,580.00	\$4,298
6+	\$59,060.00	\$4,921

All completed enrollment forms with a copy of your most recent tax return must be submitted to the following:

**Galderma Laboratories Patient Assistance Program  
122 S Michigan Ave, Suite 1100 ·Chicago, IL 60603  
Telephone: 866-730-5074 · Fax: 312-935-3599**

(Please note that the enrollment form will serve as a prescription except where applicable law requires you to submit a prescription.)

Once an application is received, patient eligibility will be evaluated. If the patient is approved, the patient will receive a prescription voucher within 8 days and will be able to pick up the medication at any local pharmacy. If the patient is denied, a denial letter will be sent to the patient the same day.

Sincerely,

Galderma Laboratories, L.P.

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**GALDERMA**  
Committed to the future  
of dermatology



## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone#: \_\_\_\_\_

Is the Patient a legal U.S. Resident? Yes  No   
What is your total annual Household Income including Social security and pension benefits? \$ \_\_\_\_\_  
How Many residents are there in your Household? 1  2  3  4  5  6+

**CHECK HERE!**

*In checking this box, I affirm that the above information is correct and that I do not qualify/am not eligible for any private insurance prescription coverage, am not enrolled in Medicare Part D, and do not qualify for any state/federal assistance with my prescription medication. (Failure to check this confirmation will eliminate the patient from the benefits of our program.)*

\_\_\_\_\_  
*Patient or Legal guardian's signature* \_\_\_\_\_  
*Date*

*Legal guardian's name and Social Security Number:* \_\_\_\_\_

## LICENSED PRACTITIONER INFORMATION

Galderma Laboratories, L.P. provided prescription drugs under this charitable program only upon the written request of a licensed physician and only for the use of an identified patient with a medical need for the drug who cannot afford it. These drugs are not to be sold, traded, or used for any other purposes.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Professional Designation: \_\_\_\_\_ (MD, DO, Other)  
Office Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
DEA# or NPI# \_\_\_\_\_ (if you do not have a DEA Number, please attach your state license)  
Telephone #: \_\_\_\_\_  
Contact Person in the office: \_\_\_\_\_

\_\_\_\_\_  
*Licensed Practitioner's signature (No stamped signature)* \_\_\_\_\_  
*Date*

## PRESCRIPTION INFORMATION

New Request

Repeat Request

- Clobex® (clobetasol propionate) Spray, 0.05%, 4.25 oz
- Differin® (adapalene) Lotion Pump, 0.1%, 2 fl oz
- Differin® Gel (adapalene gel), 0.3%, 45 gm
- Epiduo® (adapalene and benzoyl peroxide) Gel 0.1%/2.5%, 45gm
- MetroGel® (metronidazole topical gel) Topical Gel, 1.0%, 60 gm
- Oracea® Capsules (doxycycline, USP) 40 mg
- Vectical® (calcitriol) Ointment 3mcg/g, 100g