

GTx, Inc. Patient Assistance Program
P.O.Box 8203
Somerville, NJ 08876
Phone (866)325-8231 Fax (866)694-2546

DIRECTIONS FOR ENROLLMENT

PLEASE NOTE THAT AN INCOMPLETE APPLICATION WILL DELAY THE PROCESSING OF YOUR ORDER

- Complete the application in its entirety, including all insurance eligibility questions.
- Have the patient sign the **Patient Statement Section**.
- Have the practitioner sign the **Practitioner Statement Section**.
- Attach an original prescription for FARESTON® (toremifene citrate) Tablets.
- Attach a photocopy of the patient’s most recent federal tax return [1040]. If the patient does not file a federal tax return please provide a photocopy of the most recent Social Security statement, SSA, 1099, pension statement, interest, etc.
- **Medicare Part D patients please attach a photocopy of the front and back of your Medicare Part D prescription insurance card and a pharmacy printout or other documentation that shows your out of pocket prescription expenses for the current calendar year to date.**
- **Patients without prescription insurance of any kind should attach a pharmacy printout or other documentation that shows your out of pocket prescription expenses for the current calendar year to date.**

Please fax your information to (866) 694-2546 or mail to:

GTx, Inc. Patient Assistance Program P.O. Box 8203 Somerville, NJ 08876

PROGRAM ELIGIBILITY

- Patient cannot have any private prescription coverage, including an HMO or PPO plan.
- Patient cannot have government prescription coverage, other than Medicare Part D, including Medicaid, Veteran’s Administration or other state or local programs.
- Patient must be a resident of the United States.
- Patient’s household income must not exceed the guidelines listed below (for households with more than 6 persons, please call (866) 325-8231):

Income Criteria by Household Size

1 person.....	\$45,000
2 persons.....	\$60,000
3 persons.....	\$75,000
4 persons.....	\$90,000
5 persons.....	\$105,000
6 persons.....	\$120,000

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PATIENT SECTION		
NAME:	SOCIAL SECURITY#:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	PHONE NUMBER:	
DOES THE PATIENT HAVE OR QUALIFY FOR PRESCRIPTION COVERAGE WITH ANY GOVERNMENT PROGRAM INCLUDING MEDICAID, VETERAN'S ADMINISTRATION OR ANY STATE OR LOCAL PROGRAM? YES NO		
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE WITH MEDICARE PART D? YES NO <i>(If YES, please attach a copy of the front and back of your Medicare Part D prescription insurance card)</i>		
HAS THE PATIENT SPENT \$600 OR MORE OUT OF POCKET THIS YEAR FOR THEIR MEDICATIONS? YES NO <i>(If YES, please attach a pharmacy printout or other document that shows out of pocket prescription expenses for the current calendar year to date)</i>		
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE IN ANY PRIVATE PROGRAM INCLUDING AN HMO OR PPO? YES NO		
IS THE PATIENT A U.S. RESIDENT? YES NO		
WHAT IS THE PATIENT'S TOTAL <u>ANNUAL</u> HOUSEHOLD INCOME INCLUDING SOCIAL SECURITY & PENSION BENEFITS? \$ _____		
HOW MANY RESIDENTS ARE IN THE PATIENT'S HOUSEHOLD? (Check box) 1 2 3 4 5 6+		

I understand that GTx, Inc. has retained a third party administrator to receive, evaluate and process this application. I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to the third party administrator all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the GTx, Inc. Patient Assistance Program. I also authorize the third party administrator retained by GTx, Inc. to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. I understand that the information I provide will be considered confidential patient information and any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent or such is required by law. I verify that the information provided in this application is complete and accurate and I have insufficient financial resources to pay for the prescribed therapy. I understand that GTx, Inc. reserves the right at any time and without notice to modify the form of application or modify or discontinue this program and the related eligibility criteria. I authorize GTx, Inc. and its administrator to use my Social Security number for identification purposes and record keeping only.

Patient or Legal Guardian's Signature

Date

LICENSED PRACTITIONER SECTION		
NAME:	PROFESSIONAL DESIGNATION (MD, DO, etc.):	
STREET ADDRESS <i>(No P.O. Boxes please):</i>		
CITY:	STATE:	ZIP CODE:
PHONE#:	FAX #:	CONTACT NAME:
PRACTITIONER DEA# <i>(If you do not have a DEA number, please attach a copy of your current state license):</i>		

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that GTx, Inc. reserves the right to modify or terminate this program at any time. Furthermore, my signature certifies that the product will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that GTx, Inc. reserves the right to recall the product if necessary.

Original Signature of Licensed Practitioner (No signature stamps)

Date