



## HYALGAN REIMBURSEMENT AND PATIENT ASSISTANCE PROGRAM

PO Box 1074  
San Bruno, CA 94066  
Phone: (866) 749-2542  
Fax: (877) 366-0584

### Reimbursement Services Instructions:

- Please complete the application in its entirety.
- Please copy and attach Patient's insurance cards.
- The Physician must sign the application.
- **Fax the application to:** (877) 366-0584.

### Patient Assistance Instructions:

- Please complete the application in its entirety including the prescription section.
- Please have the patient sign the **Patient Certification and Authorization to Disclose Information** section.
- Please have the Physician sign the application.
- **Fax the application to:** (877) 366-0584

### Patient Assistance Program Eligibility:

- Patient must be a legal resident of the 50 United States.
- Patient cannot have or qualify for any product drug coverage.
- Patient's total yearly household income must be at or below the limits shown in the chart below.

Household Size	Total Annual Household Income	Total Monthly Household Income
1	\$27,225	\$2,268
2	\$36,775	\$3,054
3	\$46,325	\$3,860
4	\$55,875	\$4,656
5	\$65,425	\$5,452
6	\$74,975	\$6,247
7	\$84,525	\$7,043
8	\$94,075	\$7,839



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Hours of operation: Monday through Friday between the hours of 9am and 8pm (EST)

Phone: 866-749-2542 Fax: 877-366-0584

<b>(Please Check One)</b>		<b>Reimbursement Services</b> <input type="checkbox"/>	<b>Patient Assistance Services</b> <input type="checkbox"/>
<b>Patient Information</b>			
First Name:		Last Name:	
Address:			
City:		State:	Zip:
Phone Number:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Date of Birth:		SS#:	
<b>Primary Insurance</b>		** (Please include copies of the front and back of your patient's insurance cards)**	
Name:		Policy #:	Group #:
Subscriber's Name:		Date of Birth:	
Address:			
City:		State:	Zip:
<b>Secondary Insurance</b>			
Name:		Policy #:	Group #:
Phone No.:		Effective Date:	
Subscriber's Name:		Date of Birth:	
Address:			
City:		State:	Zip:
<b>Patient Assistance (For Patient Assistance Consideration Only)</b>			
1. Does the patient have or qualify for prescription drug coverage in any government program?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Is the patient a legal U.S. resident?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. How many people are in the patient's household?			
4. What is the total ANNUAL household income? \$			
Patient Certification and Authorization to Disclose Information: I verify that I am a legal resident of the United States and that the information provided in this enrollment form is current, complete and accurate. I authorize Interpace BioPharma, LLC. and its representatives and agents through the Program to obtain information from, and to share information with, my health care providers and insurance companies to determine my eligibility in the Hyalgan Patient Assistance Program (the "Program") and to provide any services through the Program. Likewise, I authorize my health care providers and insurance companies to disclose any information about me to the Program for such purposes. I understand that my assistance in the Program is contingent upon my ability to meet certain eligibility criteria set by Fidia Pharma USA Inc. I also understand that Interpace BioPharma, LLC reserves the right, at any time, and without notice, to modify or discontinue the Program and its eligibility criteria, or terminate assistance. I understand that if I do not to sign this authorization, the Program will be unable to provide any services to me. I understand that I can cancel this authorization at any time in writing to the Program at the address below; however, if I cancel this authorization, then the Program will no longer be able to provide me with assistance. I understand that once the Program receives information about me, federal privacy laws may no longer apply. However, I also understand that the Program will only use or disclose my information to determine whether I have prescription coverage for Hyalgan, to assess my eligibility for participation in the Program, to provide any other services through the Program, to operate and manage the Program or as otherwise may be permitted or required by law.			
<b>Patient's Signature (Only Required for PAP Consideration):</b>			<b>Date:</b>
<b>Therapy and Diagnosis Information</b>			
Injection Site: Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Bilateral <input type="checkbox"/>		Dispensing Site: Physician Office <input type="checkbox"/> Patient Obtain Through Retail Pharmacy <input type="checkbox"/>	
Strength:		Dose:	Sig.
Quantity:		Length of Therapy:	
Primary Diagnosis (ICD-9 Code plus description):			
Secondary Diagnosis (ICD-9 Code plus description):			
<b>Prescriber Information</b> <input type="checkbox"/> Shipping Address			
First Name:		Last Name:	
Site Name:			
Address:			
City:		State:	Zip:
Phone No.:		Fax No.:	
NPI#:		Tax ID:	
State License Number:		Specialty:	
Office Contact Name:		Contact Phone Number:	
I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Hyalgan® (sodium hyaluronate) based on my professional judgment of medical necessity. I authorize Fidia Pharma USA Inc and its representatives and agents through the Hyalgan Reimbursement and Patient Assistance Program ("the "Program") to investigate insurance coverage and information and any other Program-related services that I may request for the above name patient. If the patient has limited or does not have any public or private insurance coverage for Hyalgan and meets the required income and other criteria set by Fidia Pharma USA Inc. I understand that this patient may be eligible for participation in patient assistance through the Program. If I become aware of a change in income or insurance status that may affect my patient's participation in the Program, I will alert the Program of these changes. My signature certifies that any patient assistance products received from the Program will be used for the above named patient only and will not be resold nor offered for sale, trade or barter, will not be submitted for reimbursement from any public or private insurance company and will not be returned for credit.			
<b>Signature of Licensed Doctor or other Healthcare Provider (no stamps) :</b>			<b>Date</b>