



## ALPHARMA Patient Assistance Program

The Alpharma Patient Assistance Program offers medications to needy patients. The determination of a patient's need is made in accordance with the guidelines established by Alpharma. Alpharma reserves the right at any time and for any reason to discontinue, suspend or otherwise revise the aid or assistance provided under the Patient Assistance Program.

### **Application Instructions:**

This form has been sent to you so you may apply to receive medication on behalf of the Alpharma Patient Assistance Program. In order to process your application, it must be complete and legible. Each block, line, or space must have an entry. If something does not apply, or if the answer is none, please write "N/A".

***Incomplete applications cannot be processed and will delay the review process.***

### **Physician to Complete**

- Physician Information Section 1 - complete, date and sign. An original signature and physician's specialty is required. A stamped signature will not be accepted.

### **Patient to Complete**

- Patient Information Section 2 - All lines must be completed and legible.
- Insurance Information - Indicate if you have medical and or prescription drug coverage that pays for any part of the cost of your medication.
- Financial Information – Indicate the annual household income, less annual out-of-pocket medical costs and the total net annual income. Financial documentation must be attached. (Acceptable documentation include IRS Form 1040, 1040EZ, 4506T, 1099, social security or disability statement etc.)
- Patient Certification – **Must be signed** by patient or caregiver (indicating the relationship if family member signs for you). Indicate the current date.

### **\* In order for your completed application to be processed:**

1. Please enclose a valid prescription for KADIAN® C-II (Morphine Sulfate Extended-Release) Capsules
2. Include a money order for \$5.00 payable to Alpharma (to cover the cost of shipping and handling)
3. Financial documentation.

***If the prescription or money order, or financial documentation is missing, the application cannot be processed and will delay the review process. If your application is denied, your money order will be returned to you.***

**Please mail completed application, original prescription, financial documentation and money order to:**

**Triple i  
Atn: Alpharma Patient Assistance Program  
P.O. Box 2110  
Morrisville, PA 19067-0610**



## Alpharma Patient Assistance Program Enrollment Application

**IMPORTANT - PLEASE COMPLETE THIS APPLICATION AND FOLLOW THE INSTRUCTIONS BELOW:**

1. Enclose a 30 day valid prescription for KADIAN® C-II (Morphine Sulfate Extended-Release) Capsules
2. Include a money order for \$5.00 payable to Alpharma (to cover the cost of shipping and handling)
3. Attach Proof of Income (Acceptable documentation include IRS Form 1040, 1040EZ, 4506T, 1099, social security or disability statement, etc.)

**SECTION 1 PHYSICIAN INFORMATION**

Physician Name		DEA #	
Address			
City		State	Zip Code
Office Phone Number (      )		Office Fax Number (      )	
What is your specialty? <b>(Required)</b> <input type="checkbox"/> Pain Management <input type="checkbox"/> Oncology <input type="checkbox"/> Other _____			
Physician's signature <b>(Required)</b>			Date
<b>X</b>			

**SECTION 2 PATIENT INFORMATION**

**USE AND RELEASE INFORMATION FOR PATIENT ASSISTANCE PROGRAM ("PROGRAM")**  
 I allow my doctor listed here and my health plans, if any, to use, share, and release my information requested by the Program. This information includes my name, information from my medical record, health plan information and financial information. My information will be given to Alpharma and any other contractors or partners that help with the Program. My information will be treated confidentially to the extent required by law. Federal law may allow someone who gets my information based on this form to use or release it in some way not discussed here. This permission ends one year after my application is accepted or denied. I can choose not to sign this form or cancel this permission anytime. If I want to cancel this permission to my doctor or health plans, I will write to my doctor or health plans. My cancellation will not apply to information already obtained by health care providers and health plans if they have already used or released my information, or acted in reliance on my permission. Not signing this form will not affect my health care treatment outside the Program, health plans' payment for health care, or my ability to get benefits from health plans.

Name		Home Phone	Work Phone
Address (will not ship to P.O. box)			
City		State	Zip Code
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Soc. Sec. No./ID No.	US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Legal Resident Alien <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of people in household:		Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Other _____	

**SECTION 3 PATIENT INSURANCE INFORMATION**

<b>Private Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicare</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicaid</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Prescription Drug Coverage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Discount Card</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**SECTION 4 PATIENT FINANCIAL INFORMATION**

Annual Household Income	\$	(per year)
Less Annual Out-of-Pocket Medical Costs	\$	
<b>Total Net Annual Income</b>	<b>\$</b>	

**SECTION 5 PATIENT SIGNATURE**

My signature certifies that the information on this form is true and correct. I am not currently receiving Medicaid benefits or other prescription coverage benefits. I consent to the release by my health care providers of my medical information pertaining to the Patient Assistance Program to be used for program authorization purposes. I authorize Alpharma and its agents and assignees to use the information on this application to process the request for medication from the Patient Assistance Program and further authorize the use of my social security number for identification purposes and record keeping. I understand Alpharma reserves the right at any time without notice to modify or discontinue this program and its eligibility criteria.

Patient's or Caregiver signature <b>(Required)</b>	Date
<b>X</b>	

**Triple i**  
**Attn: Alpharma Patient Assistance Program**  
**PO BOX 2110 • Morrisville, PA 19067-0610 • Phone : 888-206-9743**