



Patient Assistance Program Application – Instruction Page

The Meda Patient Assistance Program is designed to assist financially disadvantaged individuals. All applications are reviewed on a case-by-case basis and, upon acceptance, a 90-day supply of Felbatol therapy will be mailed directly to the healthcare provider for dispensing to the patient. Eligibility documents are required with the initial application for approval and, if the applicant is approved, once a year thereafter.

Eligibility Requirements:

- An annual household income of **less** than \$16,000 for individuals or \$25,000 or less for families
- No prescription insurance (including Medicaid, Medicare, or any public or private assistance program)

Please complete the entire application. Failure to complete any section or to provide all required documentation will delay the review process. Incomplete applications will be returned for further information.

Part I. Applicant Information: To be completed by the applicant or applicant's representative.

- a) Monthly household income is required. Income includes salary, pension, Social Security income, etc. for **all** members in the household. Documentation of income is required. Documentation includes a Federal tax return, for **all** members in the household.
- b) A copy of Medicare card or letter of Medicaid and/or Social Security denial is required.
- c) Please carefully review the patient certification and then sign and date the application. Provide documentation of authorization for applicant, if someone other than a relative of applicant is signing.

Part II. Information From Physician: To be completed by the physician. Please carefully review the certifications and then sign and date the application.

The health care professional responsible for completing the application and associated documentation shall provide such information in accordance with all applicable Federal and state laws, including but not limited to, the Health Insurance Portability and Accountability Act of 1996.

Please ensure that the application is complete. Mail the completed application and associated documentation to Meda Pharmaceuticals for eligibility review.

Approval & Shipment

The physician's office and applicant will be notified of applicant eligibility. Upon approval into the Meda Patient Assistance Program, a supply of medication will be shipped to the physician's office for dispensing to the applicant.

Refill & Requalification

It is the responsibility of the physician or office staff to contact Meda Pharmaceuticals three weeks prior to the applicant requiring further medication. If within the applicant's defined eligibility period, an additional supply of medication will be shipped to the physician's office. If not within the eligibility period, the physician will be sent a re-enrollment application on behalf of the applicant.

Questions & Comments

Please contact us:

Phone: 1-800-678-4657

Hours: 8:30 am to 9 pm

RETURN COMPLETED APPLICATION TO:

Meda Pharmaceuticals

265 Davidson Avenue • Suite 300 • Somerset, NJ 08873

Attention: Patient Assistance Program



265 Davidson Avenue
Suite 300
Somerset, NJ 08873

PATIENT ASSISTANCE PROGRAM APPLICATION (page 1 of 2)

PART I. PATIENT INFORMATION (to be completed and signed by the patient or patient representative/guardian)

Name:		Social Security #	Gender: <input type="checkbox"/> M <input type="checkbox"/> FM	
Address:			Date of Birth:	
City:			State:	Zip:
E-mail:	Phone:			

a) Financial Information Attach the most current copies of income documents for you and all dependent persons in the household. A Federal tax return must be attached. (Income documentation is required only once a year.)

Number of people in household including yourself:

Monthly income for all in household:

Salary/Wages	\$
Pension	\$
Social Security	\$
Disability	\$
Unemployment	\$
Child Support/Alimony	\$
Interest/Dividends	\$
Other Income	\$
TOTAL	\$

b) Prescription Coverage Information

Medicare	<p>Does applicant have prescription coverage through Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the Rx benefit provide coverage for the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Medicaid	<p>Has the applicant applied for financial assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, has the patient been denied assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Application Pending</p> <p>If yes, please provide a copy of denial dated within two years.</p> <p>Does applicant have prescription coverage through Medicaid coverage for the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Other Government Programs	<p>Does applicant have prescription coverage through any other state or Federal government program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Application Pending</p>
Private	<p>Does the patient have prescription coverage through private insurance/HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, does it provide (partial or full) coverage for the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name:</p>



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PATIENT ASSISTANCE PROGRAM APPLICATION (page 2 of 2)

c) Certification

In the event that I am eligible for the Meda Patient Assistance Program (PAP), I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that the Program may be changed or discontinued at any time. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I acknowledge that the Meda PAP may send me additional information about the Program, information about alternate or additional financial assistance, or information about any medical condition from time to time. I certify that the information I have provided in this Application is correct and complete.

Applicant's Signature:

Date:

Note Applicant's Representative: *If the Applicant is unable to sign, or has designated signature authority, the Applicant's Representative may sign this Application. However, only certain individuals may qualify as the Applicant's Representative for purposes of this Application. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant's financial and health care status to verify that all responses provided are accurate. An appropriate consent from the Applicant, attesting to the Representative's possession of this knowledge or information must be on file if the Applicant's Representative is someone other than a relative of the Applicant. A person or entity in the supply chain of the product to be received through the PAP, including a healthcare provider or pharmacy receiving the free medicines, may not be named a Representative.*

Signature of Applicant's Representative:

Date:

Relationship:

PART II. Physician Information (to be completed and signed by the patient's physician)

Name:

Office Contact/Title:

State License #

Office Shipping Address (No PO Box):

City:

State:

Zip:

Office Mailing Address (No PO Box):

City:

State:

Zip:

E-mail:

Phone:

Fax:

a) Felbatol Prescription Information (an original signed prescription is required)

Tablets or Suspension (circle one)

Strength _____

Sig: _____

b) Certifications

1. Authorization for Release of Health Information: By signing this Application, I represent to Meda that I have obtained all necessary Federal and state consents from my patient to allow me to release health information to the Meda Patient Assistance Program.

2. Physician/Care Coordinator Verification: I verify that the information provided is complete and accurate to the best of my knowledge. I understand that Meda will send the medication to my office for dispensing to my patient. Meda reserves the right to request additional information if needed and to change or discontinue this program at any time without notice. By signing this form, I certify that I am prescribing the aforementioned medication for a patient participating in the Meda Patient Assistance Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer.

Physician's Signature (STAMPS NOT ACCEPTED)

Specialty:

Note: Physician may not delegate signature authority.

Date:

