

MYLAN/UDL PATIENT ASSISTANCE PROGRAM

POLICIES AND PROCEDURES

The Mylan/UDL Patient Assistance Program is a voluntary public service program, which will provide medication to patients in need of assistance. This program will be administered through a Clozapine Prescription Access System™ registered pharmacy. To be eligible for this program, a patient must meet the following criteria:

- The physician feels the patient is indigent and/or in need of patient assistance (*By filling out and signing the request form the physician is requesting assistance for their patient and assures that their patient is financially unable to pay for Clozapine.*)
- The pharmacy, patient, and physician must all be registered with the Clozapine Prescription Access System™.
- The patient is a resident of the United States.
- A physician must complete the "Eligibility Request Form" in its entirety.
- The application must be completed with a physician's and pharmacist's signature.

**NO ONE CAN ACCEPT DELIVERY OF CLOZAPINE WITHOUT APPROPRIATE
REGISTRATION WITH THE
Clozapine Prescription Access System™!**

To Register Call 800-843-9915, or visit our website at www.mylan-clozapine.com

All completed forms for Patient Assistance Program products should be mailed or faxed to:

**Mylan Clozapine Patient Assistance Program
P.O. Box 4310
Morgantown, WV 26504-1310
Phone: (888) 823-7835
Fax: (877) 835-4329**

Mylan will verify all requests and send the medication directly to the appropriate pharmacist for patients approved under the Patient Assistance Program. Quantities sent will be 3 months of therapy.

**Mylan Clozapine Tablets will be distributed in stock bottles of 100.
UDL Clozapine Tablets will be distributed in unit dose packages of 100.**

Patient Specific White Blood Cell (WBC) Count

Clozapine is an atypical antipsychotic drug indicated for the management of severely ill schizophrenic patients who fail to respond adequately to at least two standard antipsychotic drugs. Because of the risk of agranulocytosis and granulocytopenia associated with the use of Clozapine, drug dispensing will be contingent upon receipt of White Blood Cell (WBC) count test results. Drug provided through the Patient Assistance Program must be shipped to and stored at the Clozapine Prescription Access System™ registered pharmacy designated in Section *IIc* of the Eligibility Request Form. Medication will be dispensed to the patient in the prescribed amounts either weekly or bi weekly pursuant to the product labeling and Clozapine Prescription Access System™.

**Mylan/UDL PATIENT ASSISTANCE PROGRAM
ELIGIBILITY REQUEST FORM**

I. PRODUCT REQUESTED:

	Bottle 100	Unit Dose	Dosage	Sig.
Clozapine Tablets 25mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Clozapine Tablets 100mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

A MAXIMUM 3-MONTH SUPPLY WILL BE SHIPPED TO THE PHARMACY DESIGNATED IN *II.C.*

To be eligible for Mylan's program, a patient cannot exceed the following criteria:

• MUST PROVIDE PROOF OF INCOME

Family of 1 = \$13,110; 2 = \$16,875 3 = \$21,225 4 = \$25,725 Number of dependents _____

- Provide verification of income with a federal tax form, copy of the patients' Social Security form/check, pay stub, etc.
- Provide verification that alternate pharmaceutical coverage was denied.

➤ I request the following medication for this patient and certify that this patient meets the criteria outlined. I understand that this medication will be sent to the pharmacy listed below for dispensing to the patient.

Physician Signature: _____ Date: ____/____/____

➤ I acknowledge that product should be dispensed free of charge to the patient identified below. Product will be dispensed only to the patient listed on this application. I certify that if this patient discontinues therapy of The Mylan Brand of Clozapine, I will contact customer service at 1-888-823-7835 to arrange a return of any unused product.

Pharmacist Signature: _____ Date: ____/____/____

II A. PHYSICIAN INFORMATION: (Please print)

Physician Name: _____ Office Contact: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 State License Number: _____ Expiration Date: _____
 Telephone Number: (____) _____ Fax Number: (____) _____

II B. PATIENT INFORMATION: (Please print)

Patient Initials: _____ Date of Birth: _____ Patient's Social Security Number: _____
 Patient Diagnosis or DRG Code: _____
 Application for Alternate Pharmaceutical Care: YES NO Date of Application _____
 Type of Care Applied for: Medicaid Medicare Veteran's Benefits Other

Reason Coverage was Denied: _____

II C. PHARMACY INFORMATION: (Please print)

Pharmacist Name (Contact Pharmacist for Clozapine Issues): _____
 Pharmacy Name: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 State License Number: _____ Expiration Date: _____
 Telephone Number (____) _____ Fax Number: (____) _____

To receive medication through Mylan Pharmaceuticals Patient Assistance Program, this form must be filled out in its entirety. An incomplete request will result in a delay in processing this request, and will be returned for completion.

TO ORDER: Mail or fax this form to:

Mylan Clozapine Patient Assistance Program
 P.O. Box 4310
 Morgantown, WV 26504-1310
 Phone: (888) 823-7835
 Fax: (877) 835-4329
 Mylan/Berck/UDL reserves the right to discontinue the program at any time.

For Internal Use Only
CPAS Registered?
Yes <input type="checkbox"/> No <input type="checkbox"/>
Initials: _____
Date: ____/____/____