

Mag-Tab®SR INDIGENT PATIENT REQUEST FORM - 2009

Please print or type. Entire application must be completed.

Instructions: To apply for a drug assistance program, fill in all the blanks and make sure that the physician signs it, and then mail or fax back to Niche.

My patient, _____, is taking the following medication manufactured by your company:

Drug name	Dosage	Frequency taken	Other details
Mag-Tab®SR			

My patient would like to apply for Niche's indigent patient program. His / Her annual gross income is as follows: Total Household Income must be less than \$24,000 year. Patient must apply each time requested.

Income (Social Security, Pension, Etc.) _____ Yearly Amount \$ _____

Patient Name _____ Address _____

City, State, Zip _____ Telephone _____

D.O.B. _____ Male _____ or Female _____

Patient: Please confirm that you are indigent by reading and signing this statement.

- I certify that I am not covered by any prescription medication insurance or public or private third-party payer, such as Medicaid or a Medicare supplemental plan. I am personally unable to pay for necessary medications.
- I am covered by prescription insurance, but coverage for this medication has been denied, and a copy of the denial is enclosed. I am personally unable to pay for necessary medication.
- I authorize Niche Pharmaceuticals, Inc. to use this information to access my eligibility for participation in the Indigent Patient Program, including the audit of my medical records and/or by contacting me directly to confirm my eligibility or receipt of drug. I understand that this assistance is temporary and that this program may be discontinued or changed at any time. I certify I do not have the ability to pay for my medication and that I do not have any government, private insurance or additional revenue to pay for my medication. I attest that the information I have provided is correct and complete.

Patients Signature _____ Date _____

Physician's Name _____ (please print) Date _____

Physician's DEA# _____ Phone _____

Address _____ City, State, Zip _____

Physician's Signature _____ **Ship to: Doctor** _____ **or Patient** _____

After this application has been reviewed and approved, Niche will provide to the patient a specified amount of medication. All Patients will be considered on a case-by-case basis. Each year Niche sets aside a specific amount of medication for these patients and once the yearly supply has been distributed, the program will become available the next calendar year. Niche will ship the medication directly to the patient's doctor for distribution, if not specified to be shipped directly to patients, as specified above. Processing time is approximately 2-3 weeks, so please submit requests accordingly. Doctor's prescription must specify Mag-Tab SR, or the application will not be processed. The Doctor's office must re-submit this application each time the patient needs additional product with the doctor's signature and prescription. This form may be copied.

MAIL THIS APPLICATION AND A LEGIBLE PHYSICIAN'S PRESCRIPTION TO:

Niche Pharmaceuticals, Inc. - Indigent Patient Program

P.O. Box 449 - Roanoke, TX 76262-0449

817-491-2770 or 817-491-3533 Fax