



UNINSURED PATIENT PROGRAM
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 www.nitromed.com

STEP ONE - Patient Completes

Application Date _____ / _____ / _____

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____ Gender: Male Female

Telephone _____ Date of Birth (MM/DD/YYYY) _____ Marital Status: S M D W

Social Security Number _____ Are you a U.S. resident? Yes No Are you a Veteran? Yes No

Number of Persons in Household _____ Gross Annual Household Income \$ _____

Annual Non-Reimbursed Medical Expenses \$ _____

Does the patient have any prescription coverage, including Medicare Part D? Yes No If so, please indicate: _____

Does the patient have a deductible for this medication? Yes No If so, please indicate: _____

I authorize NitroMed and its agents to use the information provided by me and my physician to assess my eligibility for participation in the NitroMed Cares™ Program. I understand that this assistance is temporary and that I will be asked to recertify my eligibility twice a year. I also understand that this program may be changed or discontinued at any time without notice. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third-party payer. I attest that the information I have provided is correct and I understand that all information will be treated confidentially.

Patient Signature: _____ Date _____ / _____ / _____

STEP TWO - Physician Completes

PHYSICIAN INFORMATION

DEA Number _____ State License Number _____ Exp Date _____

Physician First Name _____ MI _____ Physician Last Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____ Office Contact _____

Does the patient have any allergies? Yes No If so, please indicate: _____

Please indicate prescription information: _____ Medication Ships to Physician's Office

I attest that the information provided is accurate to the best of my knowledge. I understand that, if approved, NitroMed will send the product directly to my office for the duration of the patient's enrollment in the program. NitroMed 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 NitroMed Cares Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third-party payer.

Physician Signature : _____ Date _____ / _____ / _____

PROGRAM INFORMATION

NITROMED CARES™ UNINSURED PATIENT PROGRAM

No cost to patient ■ 90-day supply ■ Medication delivered to physician quarterly

NitroMed and its agents limit the collection and use of information contained on this form to that which is necessary to administer the NitroMed Cares™ Program. NitroMed and its agents will use this information only in accordance with the principles set out in the Privacy Policy and will not sell, trade or otherwise disclose any personally identifiable patient or physician information unless required to do so by law.

When completed, fax to: 888-212-7517



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