



(Doxycycline Monohydrate Capsules, USP)

Convenience Kit

### NutriDox Patient Assistance Program

P.O. Box 5836, Somerset, NJ 08875

Phone: 800-589-0840 | Fax: 732-507-7635

Healthcare Providers can apply online at [www.RxHope.com](http://www.RxHope.com)



ADVANCED VISION RESEARCH

Prescription Products

## PATIENT INFORMATION

Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Patient Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Gender:  Male  Female

Phone \_\_\_\_\_ Date Of Birth (MM/DD/YYYY) \_\_\_\_\_ Marital Status:  S  M  D  W

Social Security # \_\_\_\_\_ Are you a U.S. resident?  Yes  No Are you a Veteran?  Yes  No

Number of persons in household \_\_\_\_\_ Gross Annual Household Income \$ \_\_\_\_\_

Is the patient enrolled in any of the following insurance programs? (Please check all that apply)

Private Insurance  Medicare  Medicaid  Medicare Part D  No Prescription Coverage  Other \_\_\_\_\_  
(please specify)

If so, is the medication requested covered at all through any of the above selected programs?  Yes  No

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize Advanced Vision Research, Inc. to obtain and disclose information from physicians, insurance companies and others as necessary to verify the information provided in this application.

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PHYSICIAN INFORMATION

DEA Number \_\_\_\_\_ State License Number \_\_\_\_\_ Exp Date \_\_\_\_\_

Healthcare Provider Name \_\_\_\_\_ Designation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Office Contact \_\_\_\_\_

I verify that the information provided is complete and accurate to the best of my knowledge. Advanced Vision Research, Inc. reserves the rights 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 patient assistance program. I understand that the medication prescribed below shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PRESCRIPTION INFORMATION



(Doxycycline Monohydrate Capsules, USP)

Convenience Kit

A 90-day supply will be provided (3 Convenience Kits)

### Convenience Kit includes:

- NutriDox 75mg™ (Doxycycline Monohydrate Capsules, USP) - 30 capsules
- Theratears Nutrition® (Omega-3 supplement with Vitamin E) - 90 easy swallow softgels
- iHeat™ Portable Warm Compress System - 10 warming units for use with 1 iHeat eye mask