

OCuSOFT®

ASSISTANCE PROGRAM

PO Box 42886 • Cincinnati, OH 45242 • Phone: 800-593-7062 • Fax: 513-618-0057
Health care providers can apply online at www.RxHope.com/OCuSOFT

PHYSICIAN INFORMATION

DEA Number _____ State License Number _____ Exp. Date _____

Physician Name (Last, First, MI) _____ Designation _____

Address _____

City _____ State _____ Zip Code _____ Contact _____

Telephone _____ Fax _____ Email _____

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature _____ Date _____

PRESCRIPTION INFORMATION

Tears Again **HYDRATE™**

A Low Dose Doxycycline
ALODOX™
(Doxycycline Hyclate 20 mg Tablets, USP) Convenience Kit

PHYSICIAN:

Please indicate dosage: _____

Up to a 3 month supply will be provided

PATIENT INFORMATION

Patient First Name _____ MI _____ Patient Last Name _____

Address _____

City _____ State _____ Zip Code _____ Marital Status: S M D W

Phone _____ Date of Birth (MM/DD/YYYY) _____ Gender: Male Female

Social Security # _____ Are you a US resident? Yes No Are you a Veteran? Yes No

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

Do you have any prescription coverage for the medication prescribed? Yes No _____
If Yes, please specify

Are you enrolled in Medicare Part D? 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 as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize the OcuSoft Assistance Program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature _____ Date _____

Fax completed form or mail to the address above.