

**ProStraCARE™ Patient Assistance Program**  
**3060 Ogden Avenue Suite 201**  
**Lisle, IL 60532**  
**Phone: 1-800-SANCUSO (1-800-726-2876)**  
**Fax: 1-866-258-7480**

The ProStraCARE™ Patient Assistance Program (the “Program”) was designed to assist uninsured individuals that have no public or private prescription coverage (e.g., Medicaid, Medicare prescription drug coverage, other charitable organizations). All applications are reviewed on a case-by-case basis.

Program eligibility

- ❖ Legal Resident of US and its territories
- ❖ Must not be eligible for or have prescription drug coverage through any private or public prescription coverage program including Medicaid and Medicare
- ❖ Annual household income must be at or below 200% of the current Federal Poverty Level
- ❖ Must submit recent Federal tax return along with the application. If you do not file taxes, alternate proof of income will be required

Applicant checklist

- Complete the **Applicant Information** and **Financial Information** sections of the application in their entirety (incomplete applications will be returned as denied)
- Sign the Applicant Declaration section
- Sign the separate Patient Authorization to share health information form (no stamped signatures will be accepted)
- Include a copy of a recent Federal tax return. If you do not file taxes, the documentation support submitted should match with the selected income values on your application. Acceptable documents include:
  - W-2 forms
  - Pay statements
  - Social security, pension or retirement statements
  - Bank statements
  - Statements of interest, dividends or other income
- Send all information to the fax number and/or mailing address listed above (please be sure the physician section is completed before submitting your application)

Physician checklist

- Complete the **Therapy and Physician Information** sections of the application in their entirety
- Sign the Physician Certification (no stamped signatures will be accepted)

ProStraCARE™ Patient Assistance Program Coordinator responsibility

- ❖ Review the application for completeness
- ❖ Determine applicant qualification based on pre-established program criteria
- ❖ Notify applicant and physician of outcome of acceptance into the program
- ❖ Upon qualification, notify program distributor and/or applicable pharmacy of patient eligibility for ProStraCARE™ Patient Assistance Program.



Patient Assistance Program Application

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Applicant Information

Form with fields for First Name, M.I., Last Name, Address, City, State, Zip Code, Daytime Phone, OK to leave message?, Date of Birth, SSN, Gender, Single, Married, Widowed, Divorced, US Resident.

Financial Information

Table for financial information with columns for Salary/Wages/Unemployment, Disability, Pension/Retirement, Alimony/Child Support, Social Security, Other, and checkboxes for tax return status.

Applicant's Certification: My signature certifies that 1) I understand and I have signed the attached Patient Authorization regarding the release of my Protected Health Information (PHI)...

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

Therapy Information

Form with a box for 'Date of first cycle treated with Sancuso' and a section for 'Future date(s)' with three rows of date fields.

Physician Information

Form with fields for Physician Name, Physician License #, License Expiration Date, Practice Name, Address, City, State, Zip Code, Office Contact Name, Phone #, Fax #.

Physician Certification: My signature certifies: 1) I am duly licensed and authorized under applicable law to prescribe the medication requested in this application to the patient listed above...

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ (original signature required)