

Patient Assistance Program

Thank you for your interest in the Salix Pharmaceuticals Patient Assistance Program. Attached is a copy of the application form. It may be photocopied and used for additional patients but must have original signatures.

In order for us to process the application form, it must be complete and legible. Each block, line or space must have an entry. If something does not apply, or if the answer is none, please write "N/A." **Incomplete applications can not be processed and will delay the review process.**

REQUIRED:

Instructions For Practitioners

- Complete the Practitioner Information section.
- Provide the phone and fax numbers.
- Provide the DEA number or State License number.
- Provide diagnosis.
- Sign the application.
- Have patient fully complete the patient information section (including the signature).
- Complete the prescription section of the application and instruct the patient to mail the complete application and financial documentation to the address listed below.

Instructions For Patients

- Fully complete the Patient Information section.
- Complete the Income Information section including total gross monthly medical expenses and your total assets. Only include in the total for assets money in checking or savings accounts, certificates of deposit, stocks and bonds, IRAs, annuities and any other cash holdings. DO NOT include the dollar values of any real estate or personal belongings.
- Sign the application form.
- Attach a copy of last year's tax return and supporting documentation for proof of your income. Some examples of acceptable financial documentation are IRS Forms 1040, 1040A, 1040EZ, W2 and 1099 Social Security Statement. If you did not file a tax return, please attach an IRS Form 4506-T to verify that you did not file. If you need assistance with this form, please call the Salix Pharmaceutical Patient Assistance Program at 1-866-282-6563.

Include with the application form a copy of last year's tax return and supporting income documentation to avoid a delay. Please be sure the prescription section of the application is complete before mailing.

If the patient is approved, the medication and a refill mailer will be sent to the patient's home within 14 days. If the patient is denied, a denial letter along with the complete application and supporting documentation will be returned to the patient within 14 days.

Mail Application form to:

Salix Pharmaceuticals Patient Assistance Program
PO Box 66520
St. Louis, MO 63166-6520
Phone: 1-866-282-6563

Program or Application Questions?

Call 1-866-282-6563 to reach Salix Pharmaceuticals Patient Assistance Program.

Please print clearly. All items must be completed or application will be returned.

PRACTITIONER INFORMATION			
Last Name, First Name		Title (MD/DO/PA/NP)	DEA Number/State License Number (one is required)
Office Street Address		Phone Number ()	
City	State	Zip Code	Fax Number ()

CERTIFICATION STATEMENT

I request that the Salix Pharmaceuticals medication(s) on the enclosed prescription(s) be provided for the named herein patient who has demonstrated a medical need and is unable to afford this medication(s). To the best of my knowledge, my patient has exhausted all third party prescription coverage, including HMO, Private Insurance, State Pharmacy Program, Medicare, Medicaid, and Veteran's Assistance.

Practitioner's Signature X	Date
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PATIENT INFORMATION

Note: Medication will be sent to the patient address unless otherwise indicated.

Patient Last Name, First Name		Social Security Number or Green Card Number	US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Street Address		Patient Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F
City	State	Zip Code	Phone Number ()
List any Patient Drug Allergies	<input type="checkbox"/> N/A	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Diagnosis (ICD9 Code)

INSURANCE INFORMATION

Does the patient have private medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurer Name		Insurer Phone Number ()	
Policy ID Number		Group Number	
Does the patient have prescription drug coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is the prescription drug card a discount card only? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prescription Drug Coverage Name		Prescription Drug Coverage Phone Number ()	
Prescription Drug ID Number			
Is the patient enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, does the patient have Medicare? <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	
Is the patient enrolled in Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

• • • Please attach a legible copy of the front and back of all insurance/prescription cards • • •

INCOME INFORMATION

Include all sources of monthly income, if married report joint. Attach copies of proof of income for you and all dependents in the household.

Number of Dependents (Including self)		Total Gross Monthly Income \$
Total Gross Monthly Medical Expenses \$	Total Assets* \$ <i>*Only include money in checking or savings accounts, certificates of deposit, stocks and bonds, IRA's, annuities and any other cash holdings. DO NOT include the dollar value of any real estate or personal belongings.</i>	

I acknowledge that the information on this form is true and correct. I understand that I may be required to provide my previous year's income. I am not currently receiving Medicaid benefits or other prescription coverage benefits. I permit Salix Pharmaceuticals Patient Assistance Program to confirm with other agencies or insurance companies that I am not currently receiving Medicaid or other prescription benefits. I consent to the release by my health care providers of my medical information pertaining to prescriptions for the Salix Pharmaceuticals Patient Assistance Program to be used for program authorization purposes.

Patient's Signature X	Date
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The patient will be notified within 14 days regarding eligibility. A refill mailer will be sent with your medication.

Mail Completed Form, Financial Documentation and Prescription to:
P.O. BOX 66520 St. Louis, MO 63166-6520. Phone: 1-866-282-6563

Please print clearly and fill out completely.

PRESCRIPTION INFORMATION	
Shipping Information	
Social Security Number or Green Card Number	Patient Name
C/O	Phone Number ()
Shipping Address	Apartment Number
City	State
	Zip
Physician Information	
Physician Name	DEA Number/State License Number
Address	Phone Number ()
City	State
	Zip
List all medications you currently take	Are you allergic to any medications? <input type="checkbox"/> Yes (please list) <input type="checkbox"/> No
Prescription Information	
<p>• • • All prescription information below must be completed by physician in order to process prescription • • •</p> <p>Have your physician complete the following information or attach an original prescription from your physician. If an original prescription is being sent the directions must read as indicated below.</p>	
Valid for Salix products only – Please complete those that apply.	Date
<input type="checkbox"/> Anusol-HC® 2.5% (Hydrocortisone Cream, USP) 30 gm tube <input type="checkbox"/> Proctocort® Cream (Hydrocortisone Cream, USP) 1% 1 oz tube <i>(Note: a maximum of 3 tubes will be provided for a 90 day supply)</i>	Directions: Apply <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN as directed Quantity: _____ x 30 gm tube _____ x 1 oz tube Refills: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> Anusol-HC® (Hydrocortisone Acetate Suppository) 25 mg	Directions: Unwrap and insert one suppository rectally <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> PRN Quantity: _____ x 12 ct _____ x 24 ct Refills: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> Apriso™ (mesalamine) Extended-release Capsules .375 g <input type="checkbox"/> Azasan® (Azathioprine Tablets, USP) 75 mg <input type="checkbox"/> Azasan® (Azathioprine Tablets, USP) 100 mg <input type="checkbox"/> Colazal® (balsalazide disodium) Capsules 750 mg <input type="checkbox"/> Metozolv® ODT (metoclopramide HCl) Tablet 5 mg <input type="checkbox"/> Metozolv® ODT (metoclopramide HCl) Tablet 10 mg <input type="checkbox"/> Relistor® (methylnaltrexone bromide) Subcutaneous Injection 0.6 mL <input type="checkbox"/> Xifaxan® (rifaximin) 550 mg Tablets	Directions: Quantity: <input type="checkbox"/> 90-day supply Refills: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> MoviPrep® (PEG 3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate and ascorbic acid for oral solution) <input type="checkbox"/> OsmoPrep® (sodium phosphate monobasic, USP and sodium phosphate dibasic anhydrous, USP) Tablets	Directions:
Physician's Signature <input type="checkbox"/> Substitution Permitted X _____ <input type="checkbox"/> Dispense as Written X _____	