



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.***

INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

- 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 - REQUIRED

- 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, IRA's, 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**.

Mail Application form to:

Salix Pharmaceuticals Patient Assistance Program
PO Box 66520
St. Louis, MO 63166-6520
PHONE 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.

For questions regarding the program or application, please call Salix Pharmaceuticals Patient Assistance Program at **1-866-282-6563**.

Application Form

All items must be completed or application will be returned

PRACTITIONER INFORMATION (Please print clearly)

Last Name, First Name	Title (MD/DO/PA/NP)	DEA# /State License #(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	Date
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PATIENT INFORMATION (Please print clearly)

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

Patient Last Name, First Name	SSN 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
List any Patient Drug Allergies: <input type="checkbox"/> N/A Martial 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 #	Group#
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	Phone Number
❖ Prescription Drug ID #	
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

****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 \$ _____*

**Only include in the total for assets, 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 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	Date
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X

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**

Prescription Information
Please fill out completely

Shipping Information

SSN or Green Card #: _____ Patient Name: _____
 C/O: _____ Phone Number: _____
 Shipping Address: _____ Apt#: _____
 City: _____ State: _____ Zip: _____

Physician Information

Please Print

Physician Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 DEA#/StateLicense: _____ Phone: _____

Prescription Information

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.

All prescription information below must be completed by physician in order to process prescription.

Valid for Salix products only-Please complete those that apply.

Date: _____

- Anusol-HC® 2.5% (Hydrocortisone Cream, USP) 30gm tube**
 Proctocort® Cream (Hydrocortisone Cream, USP) 1% 1oz tube

(note: a maximum of 3 tubes will be provided for a 90 day supply)

Directions: Apply (circle one) **QD BID TID QID PRN** as directed.

Qty: _____ X 30gm tube

Qty: _____ X 1oz tube

Refills (circle one): 1 2 3

- Anusol-HC® (Hydrocortisone Acetate Suppository) 25mg**

Directions: Unwrap and insert one suppository rectally (circle one) **QD BID TID QID PRN**

Qty: _____ X 12ct **Qty:** _____ X 24ct

Refills (circle one): 1 2 3

- Azasan® (Azathioprine Tablets, USP) 75mg** **Azasan® (Azathioprine Tablets, USP) 100mg**
 Colazal® (balsalazide disodium) Capsules 750mg **Xifaxan® (rifaximin) Tablets 200mg**
 Apriso™ (mesalamine) Extended-release Capsules .375g

Directions: _____

Qty: 90-day supply

Refills (circle one): 1 2 3

- OsmoPrep™ (sodium phosphate monobasic, USP and sodium phosphate dibasic anhydrous, USP) Tablets**
 MoviPrep® (PEG 3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate and ascorbic acid for oral solution)

Directions: _____

Physician's Signature: _____

Substitution Permitted

Dispense As Written

COLAZAL manufactured by Anabolic, Inc., XIFAXAN manufactured by Patheon, AZASAN manufactured by aaiPharma, ANUSOL-HC Suppository and Cream and Proctocort Cream manufactured by Crown Laboratories. Distributed by Express Scripts for Salix Pharmaceuticals, Inc.