



PO Box 66552  
St. Louis, MO 63166-6552  
1-800-869-4514

Thank you for your interest in the Sciele Pharma, Inc. Patient Assistance Program. To be eligible for the Sciele Pharma Patient Assistance Program, patients must be a **U.S. resident**, meet specific **income requirements**, and must **not have prescription drug coverage** from an insurance provider **or be eligible for Medicare**. To avoid delay, please use the enclosed application. Please complete the following steps to apply for the Sciele Pharma Patient Assistance Program:

1. Please have your physician fully complete the physician section of the enrollment application.
2. Complete the patient, income, and insurance information sections of the enrollment application.
3. Attach financial documentation to provide proof of your income. Some examples of acceptable documentation are IRS forms 1040, 1040EZ, 4506T, 1099, and Social Security or Disability statement.
4. Both you and your physician will need to sign the form.
5. Mail the application form, financial documentation, and a valid prescription to the following address:

**Sciele Pharma, Inc.**  
**Patient Assistance Program**  
**P.O. Box 66552**  
**St. Louis, MO 63166-6552**

The prescription medicines available through the Sciele Pharma program are:

**Cognex**<sup>®</sup> (Tacrine Hydrochloride)  
**\*\*Nitrolingual Pumpspray**<sup>®</sup>  
(Nitroglycerine)  
**Ponstel**<sup>®</sup> (Mefenamic Acid)  
**Robinul**<sup>®</sup> (Glycopyrrolate)

**Robinul Forte**<sup>®</sup> (Glycopyrrolate)  
**Sular**<sup>®</sup> (Nisoldipine)  
**Triglide**<sup>®</sup> (Fenofibrate)

\*\*There are no refills allowed for Nitrolingual Pumpspray<sup>®</sup>

If the patient is approved, the requested medication, a refill mailer and an approval letter will be sent to the patient's home within 14 days. An approval letter will also be sent to the physician. If the patient is denied eligibility, a letter will be sent to the patient within 14 days.

Sincerely,

Sciele Pharma Patient Assistance Program



PO Box 6652  
St. Louis, MO 63166-6552  
1-800-869-4514

**Important: Please attach a valid prescription.**

**PRACTITIONER INFORMATION (Please print clearly)**

Last Name, First Name			DEA# or State License(one is required)		
Office Street Address					
City	State	Zip Code	Phone ( )	Fax ( )	

**CERTIFICATION STATEMENT**

I certify to the best of my ability, that the information above is correct and the prescription(s) is/are medically necessary for the above patient and that the above patient has financial need. I have received the patient's consent to enroll him/her in the Sciele Pharma, Inc. PAP, and I agree to allow Sciele Pharma, or an authorized representative, to review the medical, financial, and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. This program is not intended for long-term support. I agree to notify Sciele Pharma of any changes I become aware of that would affect the eligibility status of the patient.

Practitioner's Signature X	Date
-------------------------------	------

**PATIENT INFORMATION (Please print clearly)**

**Note: Upon approval, medication will be sent to the patient address**

Patient Last Name, First Name		Social Security or ID Number		Patient Date of Birth / /	
Patient Street Address				US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	
City	State	Zip Code	Phone ( )	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
List any Patient Drug Allergies: <input type="checkbox"/> N/A		Number of people in household (include self): (circle one) 1 2 3 4 5 6 7 other			
List any other Patient Medications:					

**PATIENT INSURANCE INFORMATION**

Do you have prescription coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive Medicare Benefits (including Medicare Part D)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive Medicaid Benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PATIENT INCOME INFORMATION**

**Note: Attach Proof of Income (Examples: Federal Tax Return, IRS Form 1040, 1040EZ, 1099, Social Security or Disability Statement)**

<b>TOTAL GROSS YEARLY INCOME</b>	\$
<b>TOTAL YEARLY ASSETS</b>	\$

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 Sciele Pharma, Inc. 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 Sciele Pharma Patient Assistance Program to be used for program authorization purposes.

Patient's Signature X	Date
--------------------------	------