

Sculptra® Patient Access Program

P.O. Box 430
Somerville, NJ 08876
Phone: (866) 310-7551
Fax: (866) 364-2016

**Initial Enrollment Instructions:**

- Patient and practitioner sections must be completed and signed (no signature stamps)
- The practitioner must complete the Prescription Information section, or include an original prescription
- Attach a copy of the patient's most recent Federal tax return
 - o **If the patient does not file a Federal tax return, please attach other proof of annual household income (i.e. W-2, 1099, social security, disability or pension statement, unemployment award letter, etc. for everyone living in the home). If the patient has \$0 household income, please attach a letter signed by the doctor or patient advocate verifying their claim.**
- Fax or mail application, prescription (if not using the Prescription Information section on the application) and the patient's proof of income to **(866) 364-2016** or mail to the address listed above
- Both the patient and practitioner will be advised in writing of any denied requests
- Notification of incomplete applications will be sent to patient or practitioner for completion
- Please allow a minimum of 2 to 3 weeks to approve your application and receive product at your practitioner's office as there are times when product supply may be limited
- Please note that obtaining Sculptra® through the Sculptra® Patient Access Program does not include the practitioners' fees.**
- Sculptra® is subject to specific criteria for diagnosis and dispensing, acceptance into the program may include a share of the cost.
- Once you qualify for free or shared cost of Sculptra® your enrollment cycle will be 18 months, with a maximum of 6 kits allowed within this cycle and after the 6th kit is requested, two weeks post this request up to 2 kits may be requested for follow-up fills.
- (2) two years from last treatment date patient can reapply for up to (2) kits for maintenance.

Refill Instructions:

- A new application needs to be submitted
 - o *Note: Proof of household income is only required upon re-enrollment*
- Patient and practitioner sections must be completed and signed (no signature stamps)
- Fax application and prescription (if not using the Prescription Information section on the application) to **(866) 364-2016** or mail to the address listed above
- Both the patient and practitioner will be advised in writing of any denied requests
- Notification of incomplete applications will be sent to patient or practitioner for completion

Program Eligibility:

- Patient must be a resident of the United States.
- Patient cannot have or qualify for state or federal reimbursement for Sculptra®.
- Patient cannot have private insurance reimbursement for Sculptra®.
- Patient claiming to have prescription coverage but no Sculptra® coverage will be required to provide insurance information.
- Practitioner must acknowledge receipt of materials regarding product administration.
 - o **TO OBTAIN MATERIALS ON PRODUCT ADMINISTRATION, PLEASE CALL 888-728-5787 (888-SCULPTRA@).**
- Practitioner must confirm that Sculptra® will be used consistent with the FDA approved indication.
- Patient's income eligibility for full or partial assistance extends up to \$80,000 annual household income as reported on the patient's Federal Income Tax return.
- The amount of patient contribution, if any, will depend on income and household size.

Please note: Valeant Pharmaceuticals North America will make every effort to grant aid when needed. This program is limited to available resources and may be revised or discontinued at any time.

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**Patient Section-The patient or his/her legal representative must complete this section.**

Name _____ **SS#** _____
Mailing Address _____ **Date of Birth** _____
City _____ **State** _____ **Zip** _____ **Phone # (____)** _____

1. Is the patient a U.S. resident? Yes No
2. Does the patient have prescription coverage for Sculptra® with any of the following:
Government Insurance (Medicaid, Veteran's Administration, state or local programs, etc.) Yes No
Medicare Part D Yes No
Private Insurance (HMO, PPO, etc.) Yes No
If you answered yes in #2 to any of the coverage types, please submit FRONT AND BACK photocopies of your Prescription Drug Insurance Plan Card or Program Card along with this application
3. What is the YEARLY HOUSEHOLD INCOME including wages, social security, disability, etc.? \$ _____ YEARLY
4. How many people, including the patient, live in the household? 1 2 3 4 5 6+

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for this medication. I authorize Valeant Pharmaceuticals North America and its agents to use my personal identifying information for the purpose of my participating in the Valeant Pharmaceuticals North America Programs. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I understand that Valeant Pharmaceuticals North America reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the Valeant Pharmaceuticals North America Programs. Valeant Pharmaceuticals North America is authorized to use my Social Security number for identification purposes and record keeping only.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE

Practitioner Section- The licensed practitioner must complete this section

NAME: _____ **PROFESSIONAL DESIGNATION: (MD, DO, ETC.):** _____
OFFICE ADDRESS: (No P.O. Box) _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
STATE LICENSE NUMBER: _____ **SCULPTRA FACILITY NUMBER:** _____
OFFICE CONTACT PERSON: _____ **OFFICE PHONE #:** _____ **OFFICE FAX #:** _____

Prescription Information Section - The prescribing practitioner must complete this section

Sculptra® Number of Kits (2 vials per kit) for above named Patient: 1 Kit 2 Kits **Last Treatment Date** ___/___/___

The use of the product for this patient is consistent with the following FDA-approved indication for Sculptra®: Sculptra® is intended for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus. YES NO

I verify that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I have read, understand and agree to all of the above. I attest that I am not on the HHS/OIG list of Excluded Individuals. I understand that Valeant Pharmaceuticals North America reserves the right to modify or terminate this program at any time. My signature certifies that goods received from Valeant Pharmaceuticals North America are for the use of the above patient only. These goods will not be sold nor offered for sales, trade or barter and will not be returned for credit. I understand that Valeant Pharmaceuticals North America reserves the right to recall the product when necessary.

LICENSED PRATITIONER SIGNATURE (NO SIGNATURE STAMPS)

DATE

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