

Carbatrol® Patient Assistance Program

PO Box 698

Somerville, NJ 08876

Phone (866) 325-8224

Fax (866) 838-5831

Thank you for inquiring about the Carbatrol Patient Assistance Program. This program is designed to assist uninsured, indigent patients. Patients must be U.S. residents and unable to afford the cost of the prescription medication. Patients can neither have nor be eligible for prescription insurance, government assistance, or other sources of funding. Patients should make every effort to seek state assistance before and during the application process.

The licensed practitioner and patient are responsible for completing the application, including pertinent income and insurance coverage. Please include the name and number of an office contact person that can provide information if needed.

Available Products:

Carbatrol 100 mg, 120 capsules per bottle

Carbatrol 200 mg, 120 capsules per bottle

Carbatrol 300 mg, 120 capsules per bottle

To enroll in the program, a licensed practitioner must follow the steps outlined below for each eligible patient:

- 1) **Make copies of the blank enrollment form for future use.**
- 2) **Complete the attached application form.**
 - **Form must be completed in full**
 - **Faxed copies will be accepted at (866) 838-5831**
 - **Patient must meet all requirements to qualify.**
 - **Licensed practitioner's DEA or state license number is required for shipment validation. (If state license, attach a copy.)**
- 3) **A COMPLETED prescription for a three-month supply must be attached to the form. This program provides medicine **THREE MONTHS AT A TIME ONLY**. You need to reapply to obtain additional supply. (Do not request refills on prescriptions.)**
- 4) **To have product shipped directly to the patient complete the application form and indicate ship to patient. This must be mailed with the ORIGINAL PRESCRIPTION to:**
Carbatrol Patient Assistance Program
P.O. Box 698
Somerville, NJ 08876
- 5) **To have product shipped directly to the physician both the completed form and prescription can be faxed to:**
(866) 838-5831

Income criteria:

| <u>Household Size</u> | <u>Income Guidelines</u> |
|-----------------------|--------------------------|
| 1 | \$ 27,075 |
| 2 | \$ 36,425 |
| 3 | \$ 45,775 |
| 4 | \$ 55,125 |
| 5 | \$ 64,475 |
| 6 | \$ 73,825 |
| 7 | \$ 83,175 |
| 8 | \$ 92,525 |

If you need additional information, please do not hesitate to call us at (866) 325-8224.

Sincerely,
Carbatrol Patient Assistance Program

The Carbatrol Patient Assistance Program is a service of Shire US Inc.
01/27/09 (MA)

FPL2009

Carbatrol® Patient Assistance Program

P.O. Box 698

Somerville, NJ 08876

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The Carbatrol Patient Assistance Program offers assistance to indigent patients who do not have or qualify for prescription insurance, government assistance or other sources of funding. The program will provide up to a **THREE-MONTH SUPPLY** of Carbatrol, based on confirmation of need by the attending physician. Applications will be considered on a case-by-case basis. While Shire US Inc. will make every effort to grant aid when needed, this program is limited by available resources and may be discontinued or revised at any time.

IF INFORMATION IS NOT CLEARLY AND COMPLETELY FILLED OUT, THIS FORM WILL BE RETURNED.

PATIENT SECTION (To be completed by patient or legal guardian)

1) *Name* _____ *SSN* _____ - _____ - _____
Address _____ *Date of Birth* _____

Phone _____
City _____ *State* _____ *Zip* _____

- 2) A. Is the patient a U.S. resident? Yes No
- B. Total ANNUAL household income, including social security and pension benefits \$ _____ ANNUAL
- C. Number of persons residing in household (including patient)

D. DOES THE PATIENT HAVE OR QUALIFY FOR PRESCRIPTION COVERAGE IN ANY OF THE FOLLOWING PROGRAMS?

| | | | | | |
|--|------------|-----------|--|------------|-----------|
| <i>Medicare Part D program</i> | <i>Yes</i> | <i>No</i> | <i>Other state/local government programs</i> | <i>Yes</i> | <i>No</i> |
| <i>If yes, is Carbatrol covered</i> | <i>Yes</i> | <i>No</i> | <i>Private insurance/HMO prescription coverage</i> | <i>Yes</i> | <i>No</i> |
| <i>Medicare prescription coverage</i> | <i>Yes</i> | <i>No</i> | <i>Private foundation prescription coverage</i> | <i>Yes</i> | <i>No</i> |
| <i>Medicaid prescription coverage</i> | <i>Yes</i> | <i>No</i> | <i>Other prescription coverage</i> | <i>Yes</i> | <i>No</i> |
| <i>Other federal (e.g., Veterans Administration)</i> | <i>Yes</i> | <i>No</i> | <i>If yes, please specify</i> _____ | | |

3) 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 public or private reimbursement or coverage of drug costs. I also certify that I am unable to afford the cost of Carbatrol. I understand that Shire 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, or to refuse to distribute any drugs under this program to any patient. Before reapplying every 3 months to the PAP, I understand that I will seek any available state or government assistance before reapplying to the Carbatrol Patient Assistance Program. I authorize Shire to use this form to administer the Carbatrol® Patient Assistance Program.

Patient or Legal Guardian Signature

Date

LICENSED PRACTITIONER SECTION (To be completed by the licensed practitioner)

*******ATTACH ORIGINAL SIGNED PRESCRIPTION*******

Prescription will be filled with 100, 200 or 300 mg capsules. The amount of Carbatrol mailed to the licensed practitioner will be that which most closely approximates a three-month supply.

1) *Name* _____ *Phone* _____
Address _____ *FAX#* _____

City _____ *State* _____ *Zip* _____
DEA or State License # _____

(If state license, please attach a copy.)

Contact: _____ **PLEASE CHECK TO SHIP TO PATIENT**

2) I represent that the information contained in this application is complete and accurate to the best of my knowledge. I certify that the use of the indicated medication is medically necessary and I will be evaluating the patient's treatment. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Shire US Inc. reserves the right to modify or terminate this program at any time or to refuse to distribute Carbatrol under this program to any patient or physician. My signature certifies that goods received from Shire are for the use of the above-named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. Shire reserves the right to recall the product when necessary.

Signature of Licensed Practitioner

Date