Shire CARES
PO Box 722
Somerville, NJ 08876
Phone (888) CARES 55
Fax (866) 838-5915

TO ENROLL DON'T FORGET TO:

- Complete the application in its entirety
    - All incomplete applications will be returned
- Have the patient sign the **Patient Statement Section**
- Have the practitioner sign the **Practitioner Statement Section**
- Attach proof of ALL household income (most recent federal tax return 1040, Social Security SSA 1099, pensions, interest, etc.)
    - If applicable, attach proof of unemployment (unemployment paystub, employer termination letter, etc.)
- Attach a brand name prescription written in **stock bottle quantity:**

Lialda® (mesalamine) 1.2g 120 count

- Check box to indicate where shipment should be delivered (no PO boxes)
    - For orders shipping to practitioner, the information may be mailed or faxed.
    - For orders shipping to patients, the information must be mailed **and** an original prescription attached.
- Complete all insurance information (if applicable)
- Complete allergy information section

Program Eligibility

- Patient cannot have or qualify for any prescription coverage, including any federal, state, or local program
    - *Exception: Patients enrolled in a Medicare Part D prescription plan may qualify*
- Patient must be a resident of the United States
- Patient's household income must meet program qualifications

Program criteria for no-cost goods:

Household Size	Household Income
1	$32,490
2	$43,710
3	$54,930
4	$66,150
5	$77,370
6	$88,590

Program criteria for cost share:

Household Size	Household Income
1	$32,491-$37,905
2	$43,711-$50,955
3	$54,931-$64,085
4	$66,151-$77,175
5	$77,371-$90,265
6	$88,591-$103,355

Lialda® is a registered trademark of Shire LLC

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Patient Information

Name of Patient

Address (no PO Boxes)

City State Zip Code

( )

Phone Number

Date of Birth SS#

1. Are you a US resident? **YES NO**
2. Have you been unemployed in 2009 and are you still unemployed? **YES NO**
3. What is the total **ANNUAL** household income, including social security and pension benefits? $________________**ANNUAL**
4. Number of persons in household: _______________
5. Are you currently enrolled in a Medicare Part D program? **YES NO**
   - ***If yes, is Lialda® covered? YES NO***
6. Do you have or qualify for prescription drug coverage in any government program? **YES NO**
7. Do you have or qualify for prescription drug coverage in any private program? **YES NO**

Primary Insurance

Plan Name Policy # Group #

( )

Phone Number Effective Date

Subscriber's Name Date of Birth

Plan Address

City State Zip

Secondary Insurance

Name Policy # Group #

( )

Phone Number Effective Date

Subscriber's Name Date of Birth

Plan Address

City State Zip

Therapy Information

Strength Dose Sig.

Quantity Days Supply

Diagnosis Information

Primary Diagnosis (ICD9 code plus description)

Secondary Diagnosis (ICD9 code plus description)

Please list any known allergies: _________________________________

Please check here if no known allergies:

Patient Statement

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other health care provider to disclose to Shire and its agents all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in Shire CARES. I also authorize Shire and its agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. 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 verify that the information provided in this application is complete and accurate. I understand that Shire reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize Shire to use my Social Security number for identification purposes and record keeping only.

In the event I am enrolled in a Medicare Part D Prescription Plan and approved for assistance in this program, I attest that I cannot pay additional out-of-pocket costs for this medication and I will not be reimbursed by my plan, and I understand that this assistance will not count toward my true-out-of-pocket costs (TrOOP) as defined under the Medicare Modernization Act.

I have read, understand, and agree to all of the above.

Patient's Signature Date

Licensed Practitioner Information

Name

Facility Name

Address

City State Zip Code

( ) ( )

Phone Number Fax Number

DEA# Professional Designation

If DEA# is not available, please provide state license number

Provider ID #

( )

Office Contact Name Contact Phone Number

Shipping information:

Please check address that you would like medication to be shipped to.

Practitioner's address ❑ Patient's address* ❑

*(*Ship to patient requires original prescription be attached.)*

Please note: **We cannot ship to a PO Box.**

Licensed Practitioner Statement

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Shire reserves the right to modify or terminate this program at any time. Furthermore, my signature certifies that these goods will be used for the above named patient only and not be resold nor offered for sale, trade, or barter and will not be returned for credit. I attest that I am not on the HHS/OIG list of Excluded Individuals. I understand that Shire reserves the right to recall the product if necessary.

Licensed Practitioner's Signature Date

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