

**TRELSTAR® REIMBURSEMENT and PATIENT ASSISTANCE APPLICATION**

P.O. Box 1265, San Bruno, CA 94066

PHONE: 1-866-755-3315 FAX: 1-877-473-6776

Hours of Operation: Monday through Friday between the hours of 9 AM and 8 PM (EST)

PATIENT INFORMATION			PROVIDER INFORMATION		
Name:			Name:		
Address:			Site Name:		
City:	State:	Zip:	Address		
Phone:			City:	State:	Zip:
SS#:	DOB:		Phone:		Fax:
Patient Diagnosis:	Prior LH-RH Therapy:		Office Contact:		
PRESCRIBING PHYSICIAN (if different from treating physician) Name:			DEA #:		NPI #:
			Payer Specific Provider #:		Tax ID#:
			State License #:		
PATIENT INSURANCE INFORMATION					
Primary Insurance			Secondary Insurance		
Company Name:			Company Name:		
Phone:			Phone:		
Policy #:		Group:	Policy #:		Group:
POLICY HOLDER INFORMATION			POLICY HOLDER INFORMATION		
Name:			Name:		
Employer:			Employer:		
SS #:			SS #:		
Relationship to Patient:			Relationship to Patient:		

Please fill out the information above and return by fax or phone. A reimbursement specialist will research the patient's benefits for Trelstar and provide a summary to the appropriate contact.

**FINANCIAL INFORMATION** (Complete only if applying for Patient Assistance Program)

Household Size:	Annual Income:
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**Benefit Verification Requested by Physician:** I authorize the **Trelstar Reimbursement Hotline** to obtain information from my patient's insurance company to verify benefits for Trelstar. By signing below, you are indicating you have the patient's written consent to release this information on file.

**PAP Requested by Physician:** To the best of my knowledge, this patient does not have prescription drug coverage (including Medicaid, county funded assistance or other public programs) for Trelstar. No claim may be made to any third party payer for payment, nor may any patient be charged, for product provided under the program. I understand that these goods may not be sold or traded and may not be returned for credit. My signature confirms that there is a valid medical need for this patient's prescription.

*If the physician's State License number is registered to an address different from the physician's shipping address, please check here  and sign below to give consent to ship to the address listed on the form.*

**Indicate product:**

Trelstar 3.75 mg       Trelstar 11.25 mg       Trelstar 22.5 mg

Physician Signature::	Date:
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**Patient Consent:** I certify that the information on this form is true and complete to the best of my knowledge. I authorize the **Trelstar Reimbursement Hotline** to obtain information from my physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of understanding my coverage for Trelstar. I understand my information will be used solely for the purposes of verification of insurance coverage, alternative coverage research and eligibility for the Patient Assistance Program and will not be shared for any other purposes except where disclosure is required by law. I understand that information regarding my insurance coverage will be shared with my physician and agents of Watson Pharmaceuticals Corporation who administer the Trelstar Reimbursement Hotline and/or the Trelstar Patient Assistance Program for treatment purposes. I also understand that Watson Pharma Inc. has the right to modify or discontinue the program without prior notification. This consent will last for one year from date of signing.

Patient Signature::	Date:
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