Form from www.needymeds.org

TRELSTAR® DEPOT 3.75 mg (triptorelin pamoate for injectable suspension)
TRELSTAR® LA 11.25 mg (triptorelin pamoate for injectable suspension)

Please fill out this application completely.

Reset Form

Patient Information

Patient Name

Address

City, State, and Zip Code

Home Phone Work Phone

Date of Birth Male / Female

Social Security Number

Insurance Information

Insurance Co. Name Policy# Group#

Address

City, State, and Zip Code

Phone Contact Name

Subscriber Name/Relation to Patient/Date of Birth

Secondary Insurance Co. Name (if applicable)

Policy# Group#

Address City, State, and Zip Code

Phone Contact Name

Financial Information

People in Household Gross Family Annual Income

PO Box 1265
San Bruno, CA 94066
Phone: 866.755.3315
Fax: 877.473.6776

Applicant Declaration and Consent

I promise that the information on this form is correct and complete. Watson Pharma and the Trelstar Support Hotline may request and obtain documentation about my, or my family's income to enroll me in the program. To confirm that I qualify for the program, my doctor will give the program information about my health. My insurer and employer may give the program information about my insurance. People who work for and with Watson Pharma to administer the program will see my health and insurance information and the information on this form, but they will use it only for this program. The program will keep my information confidential, except where disclosure is required by law. This consent will last for one year from the date I sign this form. If I change my mind before one year has passed, I can call the program's toll-free phone number and tell them that I have decided to leave the program. I can also inform my doctor, insurer, or employer in writing that I do not want them to give the program any more information. I understand that this means I will no longer be able to receive assistance from the program. I also understand that Watson Pharma has the right to change or end the program without telling me first. I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits, but that I will not be able to receive assistance from the program.

Patient Signature Date

Physician and Prescribing Information

Physician Name

Address

City, State, and Zip Code

Phone Fax

Physician's State License #

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

Indicate product:

☐ Trelstar Depot (3.75 mg) or ☐ Trelstar LA (11.25 mg)

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.

Physician Signature Date