Triax Pharmaceuticals, LLC
Patient Assistance Program
P.O. Box 42886 • Cincinnati, OH 45242
Phone: 1-800-956-0697
Fax: 1-513-618-0059

Healthcare Providers can apply online at www.RxHope.com

APPLICATION INSTRUCTIONS

Attn: ______________________ **From:** ______________________

Fax: ______________________ **Date:** ______________________

Phone: ______________________ **Number of Pages:** ______________________

Re: ______________________ **Patient:** ______________________

ELIGIBILITY & REQUIREMENTS

- Patient can not have prescription coverage through any private, state or federal program
- Patient's household income must be at or below 200% of the Federal Poverty Level
- Application must be completed and signed by the Health Care Provider and Patient
- Patient must submit annual household Proof of Income
- Medication will be shipped to the Health Care Provider for dispensing

Triax Pharmaceuticals, LLC
Patient Assistance Program
P.O. Box 42886 • Cincinnati, OH 45242
Phone: 1-800-956-0697
Fax: 1-513-618-0059

Healthcare Providers can apply online at www.RxHope.com

PHYSICIAN INFORMATION

DEA Number ______________________ State License Number ____________________________ Exp ______________

Physician Name ____ Specialty ____________________

Address ____

City ________________________ State ________ Zip Code ______________ Office Contact _____________________

Phone _________________________ Fax ________________________ Email _________________________________

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature ____ Date ___________________

PRESCRIPTION INFORMATION

Tretin•X Cream™

- ☐ 0.025%
- ☐ 0.05%
- ☐ 0.1%

Tretin•X Gel™

- ☐ 0.025%
- ☐ 0.01%

Tretin•X Indication:

- ☐ Acne
- ☐ Other __________

Minocin® Capsules

- ☐ 50mg
- ☐ 100mg

Dosage ______________

Minocin Indication:

- ☐ Acne ☐ Infection
- ☐ Gram + ☐ STD
- ☐ Gram - ☐ Other ___________

Locoid® Lipocream

- ☐ 15g tube
- ☐ 45g tube

Locoid® Lotion 0.1%

- ☐ 2oz bottle
- ☐ 4oz bottle

PATIENT INFORMATION

Patient First Name _________________________________ MI _______ Last Name ______________________________

Address ____

City ___________________________ State _______ Zip Code ______________ Marital Status: ☐ S ☐ M ☐ D ☐ W

Phone ________________________ Date of Birth (MM/DD/YYYY) _____________________ Gender: ☐ Male ☐ Female

Social Security or Visa # __________________________ Are you a U.S. resident? ☐ Y ☐ N Are you a Veteran? ☐ Y ☐ N

Number of persons in household ________ Gross Annual Household Income* $ ____________________________________

Do you have any prescription coverage for the medication prescribed? ☐ Yes ☐ No ______________________________
If yes, please specify

Are you enrolled Medicare Part D? ☐ Yes ☐ No *Attach a copy of your most recent household income verification.
(U.S. Tax Return, IRS From 1040, Social Security/Disability Statement or monthly check, W-2 forms, or pay stubs are accepted)

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize the program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature ____ Date ____________________

Fax completed application to 1-513-618-0059