



VALEANT PATIENT ASSISTANCE PROGRAM

P.O. Box 42886 Cincinnati, OH 45242 Phone: 1-800-511-2120 Fax: 1-513-618-0060
Healthcare Providers can apply for patient assistance online at www.RxHope.com.

PHYSICIAN INFORMATION

DEA Number _____ State License Number _____ Exp _____

Physician Name (Last, First, MI) _____ Specialty _____

Address _____

City _____ State _____ Zip Code _____ Contact _____

Telephone _____ 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 _____

PRODUCT INFORMATION

8-MOP Capsules per day: _____
(methoxsalen USP)

Migranal Nasal Spray Quantity: _____
(dihydroergotamine mesylate, USP)

Ancobon Capsules, 500 mg Capsules per day: _____
(flucytosine)

OxSORalen Lotion Quantity: _____
(methoxsalen USP, 1%)

Diastat AcuDial, 10 mg Quantity: _____
(diazepam rectal gel)

OxSORalen-Ultra Capsules Capsules per week: _____
(methoxsalen USP)

Diastat AcuDial, 20 mg Quantity: _____
(diazepam rectal gel)

Prostigmin Tablets, 15 mg Tablets per week: _____
(neostigmine bromide)

Diastat Gel, 2.5 mg Quantity: _____
(diazepam rectal gel)

Tasmar Tablets, 100 mg Tablets per day: _____
(tolcapone)

Mestinon, 60 mg/Syrup Teaspoons per day: _____
(pyridostigmine bromide)

Tasmar Tablets, 200 mg Tablets per day: _____
(tolcapone)

Mestinon Timespan Tablets, 180 mg Tablets per day _____
(pyridostigmine bromide)

Zelapar Tablets per day: _____
(selegiline HCl) ODT

PATIENT INFORMATION

Patient Name (Last, First, MI) _____

Address _____

City _____ State _____ Zip Code _____ Gender: M F

Phone _____ Date of Birth (MM/DD/YYYY) _____ Marital Status: S M D W

Social Security # _____ 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? Y N _____

Are you enrolled in Medicare Part D? Y N

If yes, please specify

I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive 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 Valeant Patient Assistance 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 1-513-618-0060 or mail to the address above.