



## 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](http://www.RxHope.com).

### PATIENT INFORMATION

Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Gender  Male  Female

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

Social Security # \_\_\_\_\_ Is the patient a US Citizen?  Y  N Is the patient a Veteran?  Y  N

Does the patient have ANY prescription coverage?  Y  N If yes, please indicate the Insurance Company, Policy Holder and Number, and contact # \_\_\_\_\_

- |  |   |
|--|---|
| 1. Number of dependants including the patient: _____ | 5. All other medical expenses: \$ _____ |
| 2. Patient annual household income: \$ _____         | 6. Total medical expenses: \$ _____     |
| 3. Annual physician expenses: \$ _____               | 7. Total income less expenses: \$ _____ |
| 4. Annual prescription expenses: \$ _____            |   |

*I attest that the information included in this application is correct and complete. I understand that the information on this enrollment form and my prescription drug will only be used for purposes of determining eligibility in and administering the Valeant Patient Assistance Program. I further understand that additional documentation may be requested to verify financial or insurance information. I understand that the assistance in the form of free drug is contingent upon my ability to meet program eligibility criteria, and Valeant Pharmaceuticals reserves the right, at any time and without notice, to modify or discontinue this program and its eligibility criteria. I authorize the Valeant Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application and to provide services through this program.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### PRODUCT INFORMATION



Mysoline 50mg tablets

Mysoline 250mg tablets

Number of Pills \_\_\_\_\_ Times/day: \_\_\_\_\_

Number of Pills \_\_\_\_\_ Times/day: \_\_\_\_\_

### PHYSICIAN INFORMATION

State License Number \_\_\_\_\_ Exp Date \_\_\_\_\_ DEA Number \_\_\_\_\_

Physician First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Office Contact Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Do you verify that the information provided is complete and accurate to the best of your knowledge?  Yes  No

Do you agree to have medication sent to the physician's office for dispensing?  Yes  No

I certify that the product requested is medically indicated for this patient, and I will be supervising the patient's treatments.

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

(Original signature – Stamps not accepted)

Please fax completed form to 1-513-618-0060