

VALEANT Patient Assistance Program
 P.O. Box 836
 Somerville, NJ 08876
 Phone: (866) 268-7325
 Fax: (866) 217-7164



Initial Enrollment Instructions:

- Patient and practitioner sections must be completed and signed (no signature stamps)
- The practitioner must complete the Prescription Information section, or include an original prescription written for a 6 month supply of the name brand medication** **Diastat requires Rx attached**
- Attach a copy of the patient's most recent Federal tax return
 - o **If the patient does not file a Federal tax return, please attach other proof of annual household income (i.e. W-2, 1099, social security, disability or pension statement, unemployment award letter, etc. for everyone living in the home). If the patient has \$0 household income, please attach a letter signed by the doctor or patient advocate verifying their claim.**
- Fax application, prescription (if not using the Prescription Information section on the application) and the patient's proof of income to **(866) 217-7164** or mail to the address listed above
- Both the patient and practitioner will be advised in writing of any denied requests
- Incomplete applications will be returned to either the patient or practitioner for completion
- Please allow a minimum of 2 to 4 weeks to approve your application and receive product at your practitioner's office as there are times when product supply may be limited

Refill Instructions:

- If the original application submitted contains the completed Prescription Information, the practitioner may request the first three month refill by phone, (866) 268-7325 ****Diastat requires original RX for each refill***
- At the 6 month refill, a new application needs to be submitted*
 - o *Note: Proof of household income is only required annually upon re-enrollment*
- Patient and practitioner sections must be completed and signed (no signature stamps)
- Fax application and prescription (if not using the Prescription Information section on the application) to (866) 217-7164 or mail to the address listed above ****Diastat requires original RX for each refill**
- The practitioner may request the 9 month refill by phone, (866) 268-7325 ****Diastat requires original RX for each refill***
- Both the patient and practitioner will be advised in writing of any denied requests
- Incomplete applications will be returned to either the patient or practitioner for completion

Program Eligibility:

- Patient must be a legal resident of the United States
- Patient cannot have any government prescription coverage such as Medicaid, Veteran's Administration or any state or local programs
- Patient cannot be enrolled in Medicare Part D
- Patient cannot have any private prescription coverage such as an HMO or PPO plan
- Patient's total annual household income must be at or below the program income maximum based on household size (See chart below)

Household Size	Total Annual Household Income *
1	\$27,075
2	\$36,425
3	\$45,775
4	\$55,125
5	\$64,475
6+	\$73,825

***Income totals are approximate and are subject to change**

Reimbursement support will be performed first for selected products; allowing for insurance company coverage denials to be evaluated for Patient Assistance. Options may also be available for those with insufficient coverage.

To hear a full listing of medications available please call, 1-866-268-7325 and press 1.

Please note: Valeant Pharmaceuticals North America will make every effort to grant aid when needed. This program is limited to available resources and may be revised or discontinued at any time.

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**Patient Section-The patient or his/her legal representative must complete this section.**

Name _____ SS# _____
 Mailing Address _____ Date of Birth _____
 City _____ State _____ Zip _____ Phone # (____) _____

1. Is the patient a legal U.S. resident? Yes No
 2. Does the patient have prescription coverage with any of the following:
 Government Insurance (Medicaid, Veteran's Administration, state or local programs, etc.) Yes No
 Medicare Part D Yes No
 Private Insurance (HMO, PPO, etc.) Yes No

If you answered yes in #2 to any of the coverage types, please submit FRONT AND BACK photocopies of your Prescription Drug Insurance Plan Card or Program Card along with this application

3. What is the YEARLY HOUSEHOLD INCOME including wages, social security, disability, etc.? \$ _____ YEARLY
 4. How many people, including the patient, live in the household? 1 2 3 4 5 6+

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for medication. I authorize Valeant Pharmaceuticals North America and its agents to use my personal identifying information for the purpose of my participating in the Valeant Patient Assistance Program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I understand that Valeant Pharmaceuticals North America reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the Valeant Patient Assistance Program. Valeant Pharmaceuticals North America is authorized to use my Social Security number for identification purposes and record keeping only.

 PATIENT OR LEGAL GUARDIAN SIGNATURE

 DATE

Practitioner Section- The licensed practitioner must complete this section

Practitioner Name _____ Phone # (____) _____
 Office Address _____ Fax # (____) _____
 (street address only, no P.O. boxes)
 City _____ State _____ Zip _____ State License # _____
 NPI # _____ (As it appears on your State License)
 DEA # _____
 (**DEA required if requesting Diastat, along with original Rx)

Prescription Information Section - The prescribing practitioner must complete this section

Product 1 Name:	Strength:	Quantity Per Day:	Number of Refills:
Product 2 Name:	Strength:	Quantity Per Day:	Number of Refills:
Product 3 Name:	Strength:	Quantity Per Day:	Number of Refills:

I verify that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I have read, understand and agree to all of the above. I attest that I am not on the HHS/OIG list of Excluded Individuals. I understand that Valeant Pharmaceuticals North America reserves the right to modify or terminate this program at any time. My signature certifies that goods received from Valeant Pharmaceuticals North America are for the use of the above patient only. These goods will not be sold nor offered for sales, trade or barter and will not be returned for credit. I understand that Valeant Pharmaceuticals North America reserves the right to recall the product when necessary.

 LICENSED PRACTITIONER SIGNATURE (NO SIGNATURE STAMPS)

 DATE

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