

ViroPharma Incorporated Patient Assistance Program
P.O. Box 8124
Somerville, NJ 08876
Phone 866-694-2547
FAX COMPLETED APPLICATION TO : 866-694-2549

In order to expedite the processing of this application for patient eligibility, please note the following:

- ◆ The application must be filled out **legibly** and **completely**. The practitioner will be advised via faxed letter of any illegible and/or incomplete request.
- ◆ Number in household includes everyone living in the home.
- ◆ **Annual Household Income** include all Wages, Social Security, Supplemental Security Income (SSI), disability, loans, unemployment, workman's compensation benefits, pension, alimony, child support, interest, etc. **for everyone living in the home.**
- ◆ A new prescription, indicating the patient's **current** dose/dosage regimen, must be faxed with **each** request
- ◆ A copy of recent (within past 60 days) *Clostridium difficile* laboratory results must be provided.
- ◆ Documentation/verification of income (i.e., most recent federal tax return) must be provided with the patient's first refill request.
- ◆ The practitioner will be advised via faxed letter of any denied requests.
- ◆ Product will be shipped overnight to the practitioner's office for weekday delivery only. Deliveries will be made to street addresses (No P.O. Boxes).

A maximum of 60 capsules is provided per request. An updated, **original** application and original prescription with **current** dose/dose regimen are needed every time medication is requested for an individual patient.

PROGRAM ELIGIBILITY:

- ◆ Patient must be a legal resident of the United States.
- ◆ Patient cannot currently have any government **prescription** coverage **for Vancocin** such as Medicare Part D, Medicaid, Veteran's Administration or any state or local programs.
- ◆ Patient cannot currently have any private **prescription** coverage **for Vancocin** such as an HMO or PPO plan.
- ◆ Individuals with any Vancocin prescription coverage are required to provide proof of out-of-pocket expense for Vancocin from their pharmacy.
- ◆ Patient's total annual household income must be at or below 200% of the federal poverty level. (See chart below.)

Household Size	Max Total Annual Household Income	Max Total Monthly Household Income
1	\$21,660	\$1,805
2	\$29,140	\$2,428
3	\$36,620	\$3,052
4	\$44,100	\$3,675
5	\$51,580	\$4,298
6+	\$59,060	\$4,922

PLEASE NOTE: VIROPHARMA WILL MAKE EVERY EFFORT TO PROVIDE ASSISTANCE WHEN REQUESTED. HOWEVER, THIS PROGRAM IS LIMITED TO AVAILABLE RESOURCES AND MAY BE CHANGED OR DISCONTINUED AT ANY TIME.



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PATIENT SECTION (Patient must complete this section; Please PRINT legibly)		
NAME:	SOCIAL SECURITY #:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	PHONE #:	IS PATIENT A LEGAL U. S. RESIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>
DOES THE PATIENT HAVE PRESCRIPTION (RX) COVERAGE WITH:		
Medicaid	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Any state or local program (including PACE programs)	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Veteran's Administration	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Medicare Part D	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Private Insurance (including HMO/PPO)	YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF RX INSURANCE AVAILABLE, PROVIDE FOLLOWING INFORMATION AS SEPARATE ATTACHMENT: PHARMACY NAME, PHARMACY PHONE NUMBER, DOCUMENTATION OF ACTUAL OR POTENTIAL COST OR OUT-OF-POCKET EXPENSE		
PATIENT'S TOTAL ANNUAL HOUSEHOLD INCOME INCLUDING SOCIAL SECURITY & PENSION BENEFITS IS \$ _____		
NUMBER OF RESIDENTS IN THE PATIENT'S HOUSEHOLD IS (Check box)		1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/>

I authorize ViroPharma Incorporated and their consultants to use this information to assess my eligibility to participate in the ViroPharma Patient Assistance Program. In the event that I am eligible, I understand that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that this program may be changed or discontinued at any time. I certify that I do not have the ability to pay for my medication **and that I have no government or private insurance to help pay for my medication.** By signing below I verify that the information on this application, including financial information, is complete and accurate.

Original Signature of Patient Date

LICENSED PRACTITIONER SECTION (PLEASE PRINT LEGIBLY; ILLEGIBLE FORMS WILL BE RETURNED FOR RE-SUBMISSION)		
NAME:	PROFESSIONAL DESIGNATION: (MD, DO, etc.)	
MAILING ADDRESS: <i>(No P.O. Boxes)</i>		
CITY:	STATE:	ZIP CODE:
SHIPPING ADDRESS: <i>(If different from above; No P.O. Boxes)</i>		
CITY:	STATE:	ZIP CODE:
OFFICE PHONE #:	OFFICE FAX #:	
DEA #:	<i>(If you do not have a DEA# please attach a copy of your current state license)</i>	
STATE LICENSE # AND EXPIRATION DATE:		
CONTACT PERSON IN OFFICE:	CONTACT PHONE #:	

I verify that the information is complete and accurate to the best of my knowledge. I understand that ViroPharma Incorporated will send the medication to my office for dispensing to my patient. ViroPharma reserves the right to request additional information if needed, and to change this program at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for a patient participating in the ViroPharma Patient Assistance Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government or third party insurer.

Original Signature of Licensed Practitioner **(no stamped signatures)** Date