

ViroPharma Incorporated Patient Assistance Program

Phone 866-694-2547

FAX COMPLETED APPLICATION TO : 866-694-2549

**NOTE: NEW APPLICATION REQUIREMENTS EFFECTIVE MARCH 2011**

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 whether related or not.
- ◆ **Annual Household Income** include **all** Wages, Social Security, Supplemental Security Income (SSI), disability, loans, unemployment, workman's compensation benefits, pensions, alimony, child support, interest, etc. **for everyone living in the home.**
- ◆ Documentation/verification of income must be provided. The **required** document is the Federal Income Tax Return.
- ◆ 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.
- ◆ Proof of out-of-pocket expense/**cost to patient** for Vancocin from patient's pharmacy is required.
  
- ◆ 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 private **prescription** coverage **for Vancocin** such as an HMO or PPO plan.
- ◆ 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	\$21,780	\$1,815
2	\$29,420	\$2,452
3	\$37,060	\$3,088
4	\$44,700	\$3,725
5	\$52,340	\$4,362
6+	\$59,980	\$4,998

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.



MARCH 2011



**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  NO

DO YOU, THE PATIENT, HAVE **ANY PRESCRIPTION** (RX) COVERAGE WITH:  
**Medicaid** YES  NO  **Medicare Part D** YES  NO   
**Veteran's Administration** YES  NO  **State or local program** (e.g., PACE programs) YES  NO   
**Private Insurance (including HMO/PPO)** YES  NO  If yes, you must provide proof of insurance company denial of coverage.

**IF YOU HAVE Rx INSURANCE, YOU MUST PROVIDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION:  
 PHARMACY NAME and PHONE NUMBER, DOCUMENTATION OF ACTUAL OR POTENTIAL COST (i.e., OUT-OF-POCKET EXPENSES) FOR YOUR MEDICATIONS, INCLUDING VANCOCIN.**

TOTAL **YEARLY** HOUSEHOLD INCOME – INCLUDE ALL SOURCES E.G. SOCIAL SECURITY, PENSIONS, ETC. \$ \_\_\_\_\_

**PLEASE ATTACH FEDERAL TAX FORM(S) INDICATING INCOME**

NUMBER OF RESIDENTS IN THE PATIENT'S HOUSEHOLD IS (Check box) 1  2  3  4  5  6+

I authorize ViroPharma Incorporated and their agents 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: (No P.O. Boxes) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SHIPPING ADDRESS: (If different from above; No P.O. Boxes) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

OFFICE PHONE #: \_\_\_\_\_ OFFICE FAX #: \_\_\_\_\_

DEA #: \_\_\_\_\_ (If you do not have a DEA# please attach a copy of your current state license)

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 and will only provide such product for the patient listed on this application.

Original Signature of Licensed Practitioner (no stamped signatures) \_\_\_\_\_

Date \_\_\_\_\_