



PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

Thank you for referring your patient to our Patient Assistance Program. Attached is a copy of the application form. It may be photocopied and used for additional patients.

To be eligible for free medicine from Warner Chilcott Pharmaceuticals, a patient must be a U.S. resident, must not have affordable coverage for the prescription, and the patient's total household income must be less than 200% of the federal poverty level (FPL). If the patient is eligible to enroll in a Medicare prescription drug plan and has income below 150% FPL, the patient must document that she or he does not qualify for a Medicare drug subsidy ("Extra Help"). Note that the product provided to your patient under the Patient Assistance Program does not count toward true out-of-pocket spending (TrOOP) under the Medicare Part D prescription drug benefit.

All of Warner Chilcott's oral prescription medicines are available through our program in up to a 90-day supply with up to 3 refills:

Enablex[®] (darifenacin)
Patients must reapply every year.

APPLICATION INSTRUCTIONS FOR PATIENTS - REQUIRED

- ___ Fully complete 3 sections:
 - ___ Patient Information (Section 2)
 - ___ Insurance Information (Section 3)
 - ___ Income Information (Section 4)
- ___ Sign the application.
- ___ Attach a copy of last year's tax return or other records for proof of income. Some examples are IRS Forms 1040, 1040A, 1040EZ, W2, 1099PR and 1099 Social Security Statement. If you did not file a tax return, please attach an IRS Form 4506-T, which shows that you did not file.
- ___ If you have Medicare and income below 150% FPL, attach a copy of the letter from Social Security that states you do not qualify for Extra Help with Medicare Part D drug costs.

For questions regarding this program or application, please call us at **1-800-830-9049**.

APPLICATION INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

- ___ Complete Practitioner Information Section 1. Provide phone, fax, and DEA or State License number.
- ___ Sign the Practitioner Certification section.
- ___ Have patient fully complete the Patient Information Sections 2, 3 and 4 and sign the application.
- ___ Complete the Prescription page of the application or attach a prescription with this information.
- ___ Fax or mail the application, financial documentation, and prescription to:

Warner Chilcott Pharmaceuticals Patient Assistance Program
PO Box 66553

St. Louis, MO 63166-6553

PHONE 1-800-830-9049 FAX 1-866-277-9329

If the patient is approved, the medication and a refill mailer will be sent to the patient's home within 14 days. An approval letter will also be sent to the practitioner. If the patient is denied eligibility, a letter will be sent to the patient and practitioner within 14 days.



PATIENT ASSISTANCE PROGRAM APPLICATION FORM

Warner Chilcott Pharmaceuticals is committed to improving access to our products. To qualify for free medicine, patients should not have affordable coverage for this prescription through private or public insurance. Each patient's case is handled on an individual basis.

SECTION 1 - PRACTITIONER INFORMATION (Please print clearly)

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------|-------|----------|----------------------------------------|---------|--|
| Last Name, First Name | | | Office Contact Person | | |
| Office Street Address | | | | | |
| City | State | Zip Code | Phone () | Fax () | |
| Professional Designation: (check one) | | | State License # (or DEA#, if required) | | |
| <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA | | | | | |

PRACTITIONER CERTIFICATION

I request that the Warner Chilcott Pharmaceuticals medication(s) on the enclosed prescription(s) be provided for the above-named patient who has demonstrated a medical need. To the best of my knowledge, my patient does not have affordable third party coverage for this prescription through, for example, an HMO, Private Insurance, State Pharmacy Program, Medicare, Medicaid, or Veteran's Assistance.

| | |
|-------------------------------|------|
| Practitioner's Signature X | Date |
|-------------------------------|------|

SECTION 2 - PATIENT INFORMATION (Please print clearly)

Note: Upon approval, medication will be sent to the patient address

| | | | |
|---------------------------------------------------------|-------|--------------------------------------------------------------------------------------------------|------------------------------|
| Patient Last Name, First Name | | Social Security or ID Number | Patient Date of Birth / / |
| Patient Street Address | | | US Resident Yes No |
| City | State | Zip Code | Phone () |
| List any Patient Drug Allergies: N/A | | Number of people in household (include self): (circle one) 1 2 3 4 5 6 7 | |

List any other Patient Medications:

SECTION 3 - PATIENT INSURANCE INFORMATION

| | |
|-----------------------------------------------------------------|-------------------------------------------------|
| Do you have Medicaid? | Yes No |
| Do you have Medicare? | Yes (Indicate coverage below) No |
| Original Medicare Plan | Medicare Prescription Drug Plan |
| Medicare Health Plan Without Prescription Coverage | Medicare Health Plan With Prescription Coverage |
| Do you have prescription drug coverage? | Yes No |
| If yes, is this prescription covered by your prescription plan? | Yes No |

SECTION 4 - PATIENT INCOME INFORMATION

Note: Attach Proof of Income (Examples: Federal Tax Return, IRS Form 1040, 1040EZ, 1099, Social Security or Disability Statement)

TOTAL GROSS MONTHLY INCOME \$

I hereby consent to allow Warner Chilcott and my physician to supply this information to any third party engaged to assist Warner Chilcott in the administration of the Warner Chilcott Patient Assistance Program (PAP). I understand that this information will be used solely to determine my eligibility for participation in the PAP and to administer the program, except as may be required or permitted by applicable law, and that Warner Chilcott reserves the right at any time for any reason to contact me and to request additional information.

By signing below, I verify that the information in this application, including all copies of documentation, is complete and accurate, and that I am authorized to sign this application. I also verify that I am not currently receiving benefits for this medication from Medicaid, Medicare, or other public or private insurance or assistance program. I acknowledge and agree that I shall not in any way report or count the value of the product provided to me under this Program as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit. I understand that P&GP and any third party engaged to assist Warner Chilcott has the right to verify my eligibility, including the right to audit any information provided. I also agree that I will contact P&GP if any of the information regarding prescription drug coverage or insurance changes. I also understand that Warner Chilcott has the right to contact me directly and to confirm receipt of medications and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation in the PAP at any time by mailing a letter to the PAP.

| | |
|--------------------------|------|
| Patient's Signature X | Date |
|--------------------------|------|

The patient will be contacted within 14 days regarding eligibility.

MAIL/FAX COMPLETED FORM, FINANCIAL DOCUMENTATION AND PRESCRIPTION TO

PO BOX 66553 ST. LOUIS, MO 63166-6553

PHONE 1-800-830-9049

FAX 1-866-277-9329



PATIENT ASSISTANCE PROGRAM PRESCRIPTION FORM

Prescription Information - Please fill out completely

Patient Information

Please Print

Patient Name: _____
Social Security or ID Number: _____ Date of Birth: _____
C/O: _____ Phone Number: _____
Shipping Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____

Practitioner Information

Prescriber Name: _____
DEA#/StateLicense#: _____ Phone: _____

- Enablex 7.5mg**
 Enablex 15mg

Directions: _____
Qty: 90 days supply Refills (circle one): 1 2 3

Prescriber's Signature: _____

Substitution Permitted

Date

Dispense As Written