

Wyeth

Relistor™ (methylnaltrexone bromide)

Patient Assistance Application

Wyeth Pharmaceutical Assistance Foundation
 P.O. Box 66762
 St. Louis, MO 63166-6762
Questions: Call 1-800-568-9938

ELIGIBILITY REQUIREMENTS:

Thank you for your interest in the Wyeth Pharmaceutical Assistance Foundation Relistor Patient Assistance Program. To be eligible for this program:

- Your total family household income must be at or below 500% of the Federal Poverty Level
- You must be a resident of the United States or Puerto Rico
- You cannot have any insurance or receive any benefits—including hospice benefits—that help pay for prescription drugs, such as:
 - Private insurance
 - Medicaid
 - Medicare Part A
 - Medicare prescription drug coverage (Medicare Part D)
 - State-sponsored prescription drug assistance programs
 - Employee, military, retirement, or pension program drug coverage

Pharmacy discount cards or drug company assistance programs are not insurance coverage. If you participate in these programs, you may still qualify. If your application is approved, we will send up to a three-month supply of medication to you or your health care provider.

WHAT YOU NEED TO SEND US

- 1 **This application form** filled out and signed by both you and your health care provider.
- 2 **Your original prescription form** signed by your health care provider.

Place all required documents together
 in a stamped envelope and mail to:

Wyeth Pharmaceutical Assistance Foundation
P.O. Box 66762
St. Louis, MO 63166-6762

If you have questions or need help with your application, please call a Wyeth Pharmaceutical Assistance Foundation representative at 1-800-568-9938.

PATIENT DECLARATION – PLEASE READ

I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. I certify that Patient is a U.S. or Puerto Rico resident and has no government or private insurance to pay for the medication requested, and that paying for the medication from Patient's own resources or assets would cause Patient financial hardship. I certify that Patient is not receiving any hospice services, either inside or outside of the patient's home, that are covered by any government agency (such as Medicare Part A). I agree that if this application is approved, I will not submit a claim for reimbursement or collect reimbursement from any third party for the medication. I understand that, at any time, Wyeth may modify or discontinue any or all of the Program and related eligibility criteria, or terminate assistance provided by the Program. I have read and understand the Program guidelines and agree to comply with Program requirements.

Fill Out the **APPLICATION**
(other side)

Mail

APPLICATION COMPLETED AND SIGNED
ORIGINAL PRESCRIPTION NO PHOTOCOPIES

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 St. Louis, MO 63166-6762
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Please attach written prescription
All fields must be completed

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Section 1 – Licensed Prescriber

Licensed Prescriber Name:	State License #:	Phone: ()	
		Fax: ()	
Address:	City:	State:	Zip:

Section 2 - Medication Information

Medication should be sent to: Licensed Prescriber's office Patient's address

Is the patient allergic to medications? No Yes Please list all:

List all medications the patient is currently taking:

Licensed Prescriber Attestation I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. I have read and understand the Program guidelines and agree to comply with Program requirements. I understand that, at any time, Wyeth may modify or discontinue any or all of the Program and related eligibility criteria, or terminate assistance provided by the Program. I understand that medication provided under the Patient Assistance Program is provided free of charge to eligible patients. I certify I will not bill or collect payment from any patient or any third party for Relistor provided under the Patient Assistance Program. I understand that if a patient's insurance status changes, the patient may no longer be eligible under the Program and I agree to immediately notify the Program if I become aware of changes in the patient's insurance status. I certify that the patient identified in the following section is not receiving any hospice services, either inside or outside of the patient's home, that are covered by any government agency (such as Medicare Part A). I understand that I am under no obligation to prescribe any drug and that I have not received nor will I receive any benefit from Wyeth for prescribing any Wyeth drug. I agree to abide by this certification throughout my participation in the Program and notify immediately a Program representative if any aspects of my certification are no longer applicable.

Licensed Prescriber Signature: X Specialty Date:

Section 3 - Patient Information

Patient Name:	Social Security, Green Card or Visa Number:		
Street Address:	Date of Birth:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
City	State	Zip	Phone: ()

Section 4 – Enrollment Information

Number of Household members (including self) (circle one) 1 2 3 4 5 6 7 other	U.S. Resident Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you a Veteran of the U.S. Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you Legally Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
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list All Sources, Gross Monthly Amounts

Salary/Wages \$ _____ Social Security \$ _____

Social Security Disability \$ _____ Pension/Retirement \$ _____

Child Support/Alimony \$ _____ Unemployment/Work Comp \$ _____

Total Gross Household Income Monthly: _____

Prescription Drug Coverage		
Prescription Drug Coverage: Private / Commercial Insurance	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medicaid Drug Coverage	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medicare Drug Coverage / Medicare Part D	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medicare Part A	Yes <input type="checkbox"/>	No <input type="checkbox"/>
State Elderly Drug Assistance	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Total Patient Assets: \$ _____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Section 5 – Patient Signature

Patient's or Legal Guardian's Signature: I certify that the information provided is correct and complete, I do not have the ability to pay for my medication, I am a U.S. or Puerto Rico resident, and I have no government or private insurance to pay for my medication. I have read and agree to all terms of the Patient Declaration on page 1 of this application. X	Date:
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Wyeth

This Patient Assistance Program Authorization Form authorizes your health care provider to disclose your health and medical information to Wyeth and to the Wyeth Pharmaceutical Assistance Foundation and their respective employees, representatives and agents or its suppliers (collectively, "Wyeth") in connection with your application to the Wyeth Patient Assistance Program (the "Wyeth PAP") as required by the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPAA").

Authorization.

I, _____ [First, Middle and Last Name], hereby authorize _____ [Name of Physician or Medical Group] ("Health Care Provider") to disclose my individually identifiable health and medical information described below to Wyeth solely for the authorized purposes described in this authorization form.

Description of Health and Medical Information That May Be Disclosed.

My Health Care Provider may disclose individually identifiable health and other information that supports my application to the Wyeth PAP and that may include my name, address, date of birth, social security number, financial information, medical records and the specialty of my health care provider.

Authorized Purposes.

The authorized purposes are: (1) to permit Wyeth to evaluate my eligibility for participation in the Wyeth PAP; and (2) if Wyeth, in its sole discretion, approves my request to participate, for Wyeth's administration of my participation in the Wyeth PAP.

Expiration of Authorization.

My authorization shall expire (1) when Wyeth does not approve my application for participation in Wyeth's PAP, or (2) at the conclusion of my participation in the Wyeth PAP, whichever is earlier.

Acknowledgments.

(1) I understand that Wyeth is not an entity covered by HIPAA and related federal privacy regulations and that my medical and health information may be subject to redisclosure by Wyeth and no longer protected by such federal privacy regulations. I further understand and agree that Wyeth may retain my medical and health information as disclosed to Wyeth by my Health Care Provider under this authorization after this authorization expires for purposes related to the administration of the Wyeth PAP.

(2) I understand that I may refuse to sign this authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my Health Care Provider; or to seek payment or my eligibility for benefits. However, I understand that I may not participate in the Wyeth PAP if I refuse to sign this authorization form.

(3) I understand that I may revoke my authorization at any time by providing a written notice of same to my Health Care Provider that refers to (or with a copy of) this authorization form, or as set forth in my Health Care Provider's Notice of Privacy Practices (if any). However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my Health Care Provider to Wyeth in reliance on this authorization.

Signature of Patient or Patient's Personal Representative

Date

Patient's Name

Name of Personal Representative (if applicable)

Relationship to Patient

HEALTH CARE PROVIDER MUST GIVE PATIENT AND/OR PATIENT'S REPRESENTATIVE A SIGNED COPY

Health Care Provider has verified Patient Representative's authority to act on Patient's behalf _____ (check)