Draft

PATIENT ASSISTANCE PROGRAM QUALIFICATION FORM

FAX FORM TO 1-800-226-2059
Or mail to PATIENT ASSISTANCE PROGRAM
2087 South Grant Street, Denver, CO 80210

Please print using capital letters A B C D E 1 2 3 Shade bubbles like this ● not like this ⊘ ✓

CSN

PATIENT'S INFORMATION

First Name | M.I. | Last Name

Address | ( ) Phone | ○ Male ○ Female

City | State | Zip | Date of Birth (MM-DD-YY)

1. *For Single Patients or Patients With No Dependents.* Does patient earn more than $25,000 per year? ○ Yes ○ No

2. *For Married Patients or Patients With Dependents.* Does patient earn more than $40,000 per year? ○ Yes ○ No

3. Patient's Site of Care, select one: ○ Home ○ Family Member's Home ○ Assisted Living ○ Long Term Care Facility ○ Nursing Home ○ Other _____

4. Patient's insurance and prescription drug coverage, partial or full: ○ Medicare ○ Medicaid ○ Medicaid QMB ○ Uninsured

5. Other patient coverage, please select all that apply:

○ Medicare Managed Care ○ Includes Rx
○ State/Local Government Program ○ Includes Rx
○ Federal Program ○ Includes Rx
○ Private Insurance/HMO ○ Includes Rx
○ Private Foundation ○ Includes Rx
○ Other Rx Program

If Rx included, please explain coverage

If RX coverage, name of insurance carrier

Specify other RX Program

PATIENT/APPLICANT DECLARATION:

I understand that completing this form does not ensure that I will qualify for this program. I verify that the information provided in this qualification form is complete and accurate. I agree to notify the Patient Assistance Program if I obtain prescription drug coverage or if I no longer meet the income criteria.

I authorize the program to obtain and disclose information from my prescribing physician, caregiver, and other sources, as deemed necessary, to ensure the accuracy and completeness of this application and to provide services through this program.

I understand that the program administrators reserve the right any time and without notice to modify the application form, modify or discontinue any or all of the program and related eligibility criteria; or terminate assistance provided by the program at any time.

I understand that personal identifying information provided on this form will be available to affiliated companies and their subcontractors on a need to know basis for the purposes of administering the program.

Patient or Caregiver Signature | Date

PHYSICIAN'S INFORMATION

First Name | M.I. | Last Name

Address 1 | Address 2

Address 3 | Specialty

City | State | Zip

( ) Phone | Physician's Email

( ) Fax | State License #: Place an ✳ under all alphabetical characters

DOSAGE

This section of the form will serve as the Prescription

Quantity: 90 tablets
(1 bottle of 90 tablets)

○ 5 mg tablets ○ 10 mg tablets
○ QD sig - 1 tablet daily
○ QHS sig - 1 tablet every bedtime
○ Other _____

PHYSICIAN'S/PRESCRIBER ATTESTATION:

I hereby request for the above named patient.

To the best of my knowledge this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I certify that this prescription is medically indicated for this patient and that I will be supervising the patient's treatment. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from the patient or any third party.

I have received a signed Patient Authorization to Disclose Protected Health Information from the above named patient.

Physician/Prescriber's Original Signature | Date