PATIENT ASSISTANCE PROGRAM
PO BOX 42847 CINCINNATI, OH 45242
PHONE: 844-4AGN-PAP | PHONE: 844-424-6727 | FAX: 513-618-0054

FAX TRANSMITTAL SHEET

Attn: _____ **From:** _____

Fax: _____ **Date:** _____

Phone: _____ **Number of pages including cover:** _____

Re: _____ **Re Patient:** _____

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application **MUST** be filled out in its entirety.
- FAX or MAIL completed application with income documentation to the address above.
- Healthcare Provider and Patient MUST sign the application.
- Patients at or below 400% of the current Federal Poverty Level are eligible for assistance.
- A 90-day supply of the medication(s) requested will ship to the Healthcare Provider's office.
- A copy of the original application can be faxed or mailed to the address above.

REORDER INSTRUCTIONS

- The application is valid for one year. A copy of the application signed by the Healthcare Provider can be mailed or faxed to reorder. Patient may reapply as early as one month in advance.
- Patient Income Verification is valid for one year.

PATIENT INCOME VERIFICATION

- Patient **MUST** attach a copy of his or her most recent household income verification. Acceptable forms of documentation include:

  -Copy of most recent U.S. income Tax Return, IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040PR.

  -Copy of most recent Social Security/Disability Award Letter, Benefit Statement, or monthly check.

  -Copy of most recent pay stub.

- If the patient is unable to provide documentation of his or her income, the patient may attest that they are not able to provide acceptable documentation, however they do meet the Federal Poverty Level Guidelines at the bottom of the "Patient Information" section.

PLEASE NOTE: Healthcare Providers can manage the patient assistance application process online at **www.RxHope.com/Allergan**

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PHYSICIAN INFORMATION

State License #_____ Exp. _____ TPA# (ODs Only)_____

Physician Name (First, MI, Last) _____ Designation _____

Address _____

City _____ State _____ Zip Code _____ Email _____

Telephone _____ Fax _____ Office Contact _____

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient, and I shall not seek reimbursement or professional fees for this medication from any third party. By signing below, I represent that I am disclosing this information to Allergan, its affiliates, agents, representatives, and service providers (together "ALLERGAN") to help enable treatment for this patient. I further certify that the patient is aware of, has consented to, and has directed my disclosure of his/her information to ALLERGAN to enable services to the patient for such purposed, including to perform insurance coverage verification and insurance reimbursement services, and that such consent and direction applies to disclosures made through the duration of the patient's therapy.

SIGN HERE **PHYSICIAN SIGNATURE:** _____ **DATE** _____

PRODUCT INFORMATION

- ☐ **ACZONE® Gel 5%** (dapsone) 60g, 1 tube
- ☐ **ACZONE® Gel 7.5%** (dapsone) 60g, 1 tube
- ☐ **ACUVAIL™ 0.45%** (ketorolac tromethamine ophthalmic solution) 30x.4mL, 2 boxes
- ☐ **ALPHAGAN® P 0.1%** (brimonidine tartrate ophthalmic solution) 15 mL, 3 bottles
- ☐ **COMBIGAN® 0.2%/0.5%** (brimonidine tartrate/timolol maleate ophthalmic solution) 10 mL, 3 bottles
- ☐ **LUMIGAN® 0.01%** (bimatoprost ophthalmic solution) 7.5 mL, 2 bottles
- ☐ **PRED FORTE® 1.0%** (prednisolone acetate ophthalmic suspension) 5 mL, 2 bottles
- ☐ **PRED FORTE® 1.0%** (prednisolone acetate ophthalmic suspension) 10 mL, 2 bottles
- ☐ **RESTASIS® 0.05%** (cyclosporine opthalmic emulsion) 60 x 0.4 mL, 6 trays
- ☐ **RESTASIS® MULITDOSE 0.05%** (cyclosporine opthalmic emulsion) 5.5 mL, 3 bottle
- ☐ **RHOFADE Cream™ 1%** (oxymetazoline hydrochloride) 30g, 2 tubes
- ☐ **TAZORAC® Gel 0.05%** (tazarotene) 100g, 3 each
- ☐ **TAZORAC® Gel 0.1%** (tazarotene) 100g, 3 each
- ☐ **TAZORAC® Cream 0.05%** (tazarotene) 60g, 5 each
- ☐ **TAZORAC® Cream 0.1%** (tazarotene) 60g, 5 each

PATIENT INFORMATION

Patient Name (First, MI, Last) _____ Date of Birth (MM/DD/YYYY) _____

Telephone _____ Number of Persons in Household _____

Gross Annual Household Income $ _____

Patients must attach a copy of their most recent household income verification.

By signing below, I do hereby attest that the household size and income, is true and accurate, that I meet the Federal Poverty Guidelines as stated, and that I am unable to provide acceptable documentation of income.

PATIENT SIGNATURE: _____ **DATE** _____

INSURANCE INFORMATION

Do you have Prescription Drug Coverage? ☐ Yes ☐ No

Are you enrolled in Medicaid? ☐ Yes ☐ No

Are you enrolled in Medicare Part D? ☐ Yes ☐ No

I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of the program. I hereby authorize the patient assistance program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

SIGN HERE **PATIENT SIGNATURE:** _____ **DATE** _____

*SEE ATTACHED INSTRUCTION SHEET