Patient Assistance Program
PO BOX 66764, St. Louis, MO 63166

Phone: 1 844-424-6727 Fax 844-708-0036

The Allergan Patient Assistance Program (PAP) provides Allergan medicines at no cost to eligible patients. If the patient qualifies, twelve-month eligibility for the requested medication(s) or device(s) is approved for shipment to the patient's licensed prescriber for dispensing.

Checklist for submitting an application

- All sections of the application must be completed to be considered for the program.

IF YOU ARE A PATIENT

- Refer to Page 2: Complete the Patient Information, Income Information, and Coverage Information.
- Refer to Page 3: Sign and Date Patient Certification.
- Refer to Page 4: Sign and Date Patient Authorization.
    - *Your signature and date will be valid for 12 months*
- Provide proof of income (examples include federal tax return, W-2, or current pay stubs) for the applicant.
    - Other documents for the application may include: Monthly healthcare benefits statement, Social Security award letter or bank statement showing monthly direct deposit (Social Security, Veterans Affairs).
    - Self-Employed patients must attach a copy of the most current Federal Income Tax statement with appropriate schedules (C and/or F) attached.
    - If you have no income, a letter from your physician or social worker is required on their letterhead. The letter must affirm patient's financial situation.
- For patients unable to sign the application, the Power of Attorney (POA) should include their notarized POA form.
- If you are a Medicare Part D enrollee, you should have applied for and been denied Low Income Subsidy. Please include Denial Letter.

IF YOU ARE A PRESCRIBER

- Refer to Page 2: Complete the Licensed Prescriber Information.
    - *Note: Include Medication, Quantity and Dosage requested in this section.*
- Refer to Page 5: Sign and Date Licensed Prescriber Certification.
    - *Your signature and date are valid for 12 months*.
- Requests for Viberzi must include a valid prescription, with signature
- Viberzi can only be shipped to the address registered to the prescribers DEA number. If the preprinted office address on the prescription does not match the delivery/mailing address on the application form, then you must also attach letterhead, coversheet or a business card to verify the delivery/mailing address on the application form
- In the case that a PAP product needs to be returned for any reason please call Allergan's Patient Assistance Program Phone Number - 844-424-6727 for instructions.

Fax or mail the completed application and documentation to:

- **Allergan Patient Assistance Program**
  PO BOX 66764, St. Louis, MO 63166
  Phone: 1 844-424-6727
  Fax: 1 844-708-0036
- Upon receipt of a completed application, notification of eligibility will be sent to the prescriber and patient. If approved, we will ship the medication to the licensed prescriber indicated on the application. Please allow 4 weeks for application processing and delivery of medication. Incomplete applications may be returned to the applicant or prescriber with instructions for completion. Please contact us at 1-844-424-6727 Monday through Friday 8 am – 5 pm US CST for additional assistance.

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SECTION 1.0 LICENSED PRESCRIBER INFORMATION

Prescriber Full Name and Designation:		
State License Number:		
DEA Number:	NPI Number:	
Office Contact Name:		
Office Contact Phone Number:	Office Contact Fax Number:	
Prescriber Shipping Address:		
Hospital/Surgery Center Shipping Address: (Xen ONLY)		
Medication	Quantity	Dosage

SECTION 2.0 PATIENT INFORMATION

Patient Full Name:	
Gender:	
Phone Number:	
Date of Birth:	
Mailing Address:	
Marital Status:	
Email Address:	
Number of people in household (including self):	
Are you a veteran: Yes ☐ No ☐	
Have you received disability payments from Social Security for more than 24 months? Yes ☐ No ☐	

SECTION 2.1 INCOME INFORMATION

Salary/Wages: $	Social Security: $
Alimony/Child Support: $	Disability: $
Pension/Retirement: $	Unemployment/Work Comp: $
Total Gross Monthly Income: $	

SECTION 2.2 COVERAGE INFORMATION

VA or Military Benefits: Yes ☐ No ☐	Are you enrolled in Medicaid: Yes ☐ No ☐
State Elderly Drug Assistance: Yes ☐ No ☐	Are you enrolled in Medicare: Yes ☐ No ☐
Medicare ID#	Are you enrolled in Medicare D Plan: Yes ☐ No ☐
Do you have private prescription coverage/reimbursement Yes ☐ No ☐	
Please provide the following information regarding your primary and secondary insurance plan(s). (attach additional sheets, if necessary)	
Plan Name	
Policy Holder Name	
Policy ID Number	
Group Number	
What is the co-pay/out of pocket expense for the requested medication?	
Has your insurer denied coverage for the requested medication? Yes ☐ No ☐	

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SECTION 3.0: PATIENT CERTIFICATION

I certify that all information provided in sections 2.0, 2.1 and 2.2 is correct, complete to the best of my knowledge, and that I have an obligation to update Allergan, using the contact information herein, of any changes in my financial status or insurance coverage.

I understand that Allergan Pharmaceuticals, Inc., including any agents Allergan engages to administer or otherwise support the Patient Assistance Program (the "Program") (collectively, "Allergan") may contact me to request verification of any information provided or requested on this form, which I agree to provide personally or through my employer or my insurance or other benefit provider. Completion of this form does not guarantee approval for the Program.

If approved, I certify that:

(i) I will not seek reimbursement for any drug(s) and/or device(s) requested on the prescription attached to this application from any government program or third-party payor;

(ii) If I am a member of a Medicare Part D plan, I will not apply or claim the cost of any Program drug(s) and/or device(s) toward my true out-of-pocket costs;

(iii) I will notify my insurance or other benefit provider of my receipt of any drug(s) and/or device(s) through the Program, if required by those providers;

(iv) I understand that the Program does not affect any administration fees my prescriber may charge in accordance with his or her normal billing policies; and

(v) I understand that my prescriber will receive a three-month supply of drug(s) or device(s) to dispense to me, that my prescriber must submit additional prescriptions if additional drug(s) or device(s) are requested, and that I must reapply after 12 months of being approved for the Program (or at the end of the calendar year if I am covered by a government program).

I understand that the Allergan reserves the right at any time and without notice to me to modify and/or discontinue any or all the Program, including modification of eligibility criteria, covered medications and immediate termination of assistance provided by the Program.

Patient/Legal Representative Signature: **X**	Date:
If Legal Representative, Print Name and Indicate Relationship:	

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SECTION 4.0: PATIENT AUTHORIZATION

By signing below, I hereby authorize my prescriber, pharmacy or other health care provider set forth below in Section 1.0 above to disclose and transmit my Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, as amended) to Allergan and any third party engaged to assist Allergan in administering the Patient Assistance Program (the "Program") (collectively, "Allergan") for the purposes described herein.

I understand that Allergan may disclose and transmit my PHI to my insurance or other benefit provider, including the Centers for Medicare & Medicaid Services ("CMS") and any authorized vendor(s) of such insurance or other benefit providers, for the purposes of verifying my Medicare Part D or other enrollment status, confirming coverage (or lack thereof) for the requested drug(s) and device(s), and disclosing my enrollment in the Program with my Medicare Part D plan or other insurance/benefit provider.

I understand that my PHI may include my name, address, income, prescription coverage, prescription for drug(s) or device(s), financial documents and insurance records, other information provided on this application form, and any information reasonably requested by Allergan for the purposes of (i) determining my eligibility to participate in the Program, both initially and throughout my participation in the Program, (ii) shipping appropriate drug(s) and/or device(s) as prescribed by my licensed prescriber, and (iii) administering, evaluating, and improving the Program.

I understand that signing this authorization does not guarantee that I will be accepted into the Program. I further understand that because Allergan is not covered by federal privacy regulations, after my information is disclosed to Allergan, it will no longer be protected under federal law and could be subject to re-disclosure. This authorization will expire one (1) year from the date of my signature below, as required by law, or upon execution of a new authorization pursuant to reapplication to the Program.

I may revoke this authorization at any time by providing written notice to Allergan at the address set forth above. My revocation will become effective on the date my written notice is received and processed by Allergan. If I revoke my authorization, I understand this means I may no longer be able to receive assistance from the Program. I also understand that I may refuse to sign this authorization and that doing so will not affect by prescriber's treatment of me or my eligibility for insurance benefits. I also understand I have a right to receive and/or make a copy of this authorization.

Patient/Legal Representative Signature: **X**	Date:
If Legal Representative, Print Name and Indicate Relationship:	

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SECTION 5.0: LICENSED PRESCRIBER CERTIFICATION

This Program aids financially eligible patients who need Product(s). Patients who are uninsured or underinsured and are unable to afford the cost of therapy may be eligible for enrollment. While Allergan makes every effort to grant aid when needed and appropriate, the Program is limited in available resources and may be discontinued or modified at any time, without further notice.

I certify that the use of the medication listed in Section 1 above ("Product") is medically necessary and appropriate for the individual listed in Section 2 above ("Patient"), the Product will only be used for this Patient, and that I will be supervising the Patient's treatment accordingly. I further certify that, to the best of my knowledge, this Patient has no medical insurance coverage for Product, including Medicaid/Medicare or other government programs, and the patient has insufficient financial resources to pay for the prescribed therapy.

I agree not to bill or collect from the Patient or any government or private payer, or to trade, sell, barter for or return for credit any product provided under the Program. While I agree that I will not seek payment for an office visit from the Patient or a third-party payor when the only service provided at such office visit is provision of the Product(s) to the Patient, I also certify that my Patient understands that he/she is responsible for the costs of administering Product if I am unable to waive the administration fee.

For the purposes of transmitting this prescription, I authorize Allergan and its affiliates, business partners, and agents to forward for these limited purposes this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

Licensed Prescriber's Signature: **X**	Date:

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NO FEES APPLY TO THIS PROGRAM

The following medications and devices are available through the Allergan Patient Assistance Program Medications

** Maximum amount for AeroChamber or AeroChamber with mask is one per applicant in a six-month period. All trademarks and product names herein are the property of their respective owners.*

• Acuvail® (ketorolac tromethamine 0.45%) ophthalmic solution	• Namenda ® (memantine HCl) Oral Solution
• Device: AeroChamber Plus ® Flow-Vu ® Mouthpiece*/ Flow-Vu ® Mask*	• Namenda XR ® (memantine HCl) Extended Release Capsules & Titration
• Alphagan® P (brimonidine tartrate 0.1%) ophthalmic solution	• Namzaric ® (memantine hydrochloride extended-release and donepezil hydrochloride) capsules
• Armour ® Thyroid (thyroid tablets, USP) Tablets	• Namenda ® (memantine HCl) Tablets
• Avycaz ® (ceftazidime/avibactam)	• Ozurdex® (dexamethasone intravitreal implant 0.7mg)
• Bystolic ® (nebivolol) Tablets	• Pred Forte® (prednisolone acetate 1.0%)
• Byvalson ™ (nebivolol and valsartan)	• Pylera ® (bismuth subcitrate potassium, metronidazole, and tetracycline HCL) Capsules
• Canasa ® (Mesalamine, USP)	• Rapaflo ® (silodosin) Capsules
• Combigan® (brimonidine tartrate/timolol maleate %/00.5%)	• Rectiv ® (nitroglycerin) Ointment
• Crinone ® (progesterone gel)	• Restasis® (cyclosporine ophthalmic emulsion)
• DALVANCE® (dalbavancin) for injection	• RHOFADE Cream™ 1% (oxymetazoline hydrochloride)
• Delzicol ® (mesalamine) DR Capsules	• Saphris ® (asenapine maleate) sublingual tablet
• Estrace ® (estradiol) Cream	• Savella ® (milnacipran HCl) Tablets & Titration Pack
• Fetzima ® (levomilnacipran) Extended Release Capsules and Titration Pack	• TEFLARO® (ceftaroline fosamil) for injection
• Gelnique ® (oxybutynin chloride 10 % gel)	• Trelstar ® (triptorelin pamoate) injectable suspension
• Infed ® (Iron Dextran) Injection	• Viberzi ® (eluxadoline) Tablets
• Linzess ® (linaclotide) capsules	• Viibryd ® (vilazodone HCl) Tablets & Titration Pack
• Liletta ® (levonorgestrel) Intrauterine Contraceptive Device	• Viokace ® (Pancrelipase) Tablets
• Lumigan® (bimatoprost 0.01%)	• Vraylar ™ (cariprazine) Capsules
• Monurol ® (fosfomycin) Powder	• XEN® Sterile Injector
	• Zenpep ® (Pancrelipase) Capsules