Allergan Patient Assistance Program Application

The Allergan Patient Assistance Program (PAP) provides Allergan medicines at no cost to eligible patients. Qualified patients may be approved for assistance for up to twelve months assistance. We ship most products in a 90 day supply. Participation in our program is free; we do not collect any fees from people seeking our assistance.

CHECKLIST FOR SUBMITTING AN APPLICATION

PLEASE NOTE BOTH PAGES 2 & 3 MUST BE COMPLETED AND SUBMITTED FOR ENROLLMENT CONSIDERATION.

☐ IF YOU ARE THE PRESCRIBER, COMPLETE PAGE 2

- SECTION 1: Prescriber Information
- SECTION 2: Patient Information
- SECTION 3: Medication Request
- SECTION 4: Prescriber Certification and Signature

☐ IF YOU ARE THE PATIENT, COMPLETE PAGE 3. PLEASE READ PAGE 4.

- SECTION 5: Patient Information
  - If you are requesting Viberzi® (eluxadoline) tablets, enclose a copy of a government issued ID such as: Driver's license, State ID, Military ID, etc
- SECTION 6: Financial Information
  - Please be sure to include proof of income for everyone in your household. We prefer your current tax return.
- SECTION 7: Insurance Information
  - **If you have insurance coverage**, please attach a list of your current medical and prescription drugs and their cost. If you are taking multiple prescriptions, a print-out from your pharmacy will be helpful. This information will help us review your eligibility for our program.
- SECTION 8: Patient Consent and Signature
- SECTION 9: Additional Permission for Program Purposes (Optional)

Please review to ensure that you have completed all sections and that you have included all additional requested documents. Incomplete applications could result in delays.

☐ Please keep a copy for your records.

FAX OR MAIL THE COMPLETED APPLICATION AND REQUIRED DOCUMENTATION TO:

Allergan Patient Assistance Program
PO Box 66764
St. Louis, MO 63166

Phone: 844.424.6727

Fax: 844.708.0036

Upon review of a completed application, we will notify the patient and the prescriber about eligibility. If approved, we will routinely ship medicine to the prescriber's office. Most products may be shipped to the patient's home on request. Please call 844-424-6727 to request refills.

Please contact us at 1-844-424-6727 Monday through Friday, 8am to 5pm CST for additional assistance.

PRESCRIBER PRESCRIPTION AND CERTIFICATION
TO BE COMPLETED BY PRESCRIBER

Allergan Patient Assistance Program Application

1 PRESCRIBER INFORMATION

Prescriber Name:		Designation (MD, OD, etc):
NPI:	DEA:	State License:
Office Name:		
Office Contact Name:	Phone:	Fax:
Prescriber's Shipping Address:		
City:	State:	Zip:

2 PATIENT INFORMATION

First Name:	Last Name:	Suffix:
Date of Birth:	Gender:	Phone Number:
Shipping Address (No PO Box):		
City:	State:	Zip:

3 MEDICATION INFORMATION (MUST BE COMPLETED BY LICENSED PRESCRIBER - 90 DAY SUPPLY PREFERRED)

PRODUCT	STRENGTH	QUANTITY	DIRECTIONS	REFILLS

ALLERGIES: **OTHER MEDICATIONS:**

If you are requesting Viberzi® (eluxadoline) tablets, please Use Prescriber's prescription form and submit with application

4 PRESCRIBER SIGNATURE – PRESCRIBER PLEASE SIGN AND DATE BELOW

MANUAL SIGNATURE ONLY – RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL OR COMPUTER GENERATED IMAGES ARE NOT ACCEPTED

I verify that the information provided is current, complete and accurate to the best of my knowledge. Allergan Patient Assistance Program reserves the right to request additional information if needed and to change or discontinue the program at any time, without notice. I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party, including patient, nor will I sell, trade or distribute any such medication. I also understand that the applicant's acceptance into the program should not influence treatment decisions. By signing this form, I acknowledge and agree that the designated Specialty Pharmacy receive this prescription via a designated third party, the Program, and that no additional confirmation of receipt of prescription is required by the designated Specialty Pharmacy. I authorize the program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the program for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

PRESCRIBER SIGNATURE: X_____ DATE: _____

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By signing this form, I authorize Allergan Patient Assistance Program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy for the dispensing of medication called for herein.

5 PATIENT INFORMATION

First Name:	Last Name:	DOB:
Shipping Address (No PO Box):		
City:	State:	Zip:

6 FINANCIAL INFORMATION

Monthly Total Income for everyone in the household: $ _____

Total number of people in the household (including yourself): _____ Number in household over 18 years old with income: _____

Please include financial documentation for everyone in your household. A copy of your Federal Tax Return is preferred.

7 INSURANCE INFORMATION

☐ **Check this box if you have NO insurance coverage – go to Section 8**

- If you have insurance, please identify below.
- Please attach a list of your current medical and prescription drugs and their cost. If you are taking multiple prescriptions, a print out from your pharmacy will be helpful. This information will help us review your eligibility for our program.

Private Insurance: Yes ☐ No ☐	State Elderly Ins: Yes ☐ No ☐	Veteran's Assistance: Yes ☐ No ☐
Medicaid: Yes ☐ No ☐	Original Medicare (A/B): Yes ☐ No ☐	
Are you enrolled in a Medicare Prescription Drug Plan (Medicare Part D)? Yes ☐ No ☐		
Has your insurer denied coverage of the requested medication? Yes ☐ No ☐		

What is your current total annual out-of-pocket expense for all of your prescriptions? $_____

8 PATIENT CONSENT – PLEASE REVIEW HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE IN SECTION 10 TO UNDERSTAND HOW WE USE YOUR PERSONAL INFORMATION

I acknowledge that I have provided accurate and complete information and understand the Patient Terms of Participation on Page 4.

My signature below certifies that I have read, understood, and agree to the release of my protected health information pursuant to the HIPAA Authorization in Section 10.

PLEASE SIGN: X _____ X_____

PATIENT SIGNATURE/LEGAL REPRESENTATIVE (INDICATE RELATIONSHIP) DATE

9 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (OPTIONAL)

I permit Allergan Patient Assistance Program to speak with the following person about this application:

Name: _____ Relationship: _____ Phone number: _____

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10 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

HIPAA AUTHORIZATION Please provide signature in Section 8 on Page 3 of Enrollment Form

I authorize my healthcare providers, pharmacies, insurers, and laboratory testing facilities (my "Healthcare Companies") to disclose information about me, my medical condition, treatment, insurance coverage, and payment information in relation to my use of Allergan products, to the Allergan Patient Assistance Program and Allergan, to enroll me in and provide me with assistance and support for Allergan products. I understand that information released under this Authorization will no longer be protected by HIPAA. I also understand that if my Healthcare Companies use or disclose my Personal Information for marketing purposes, they may receive financial remuneration.

I understand that I am not required to sign this Authorization and that my Healthcare Companies will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Allergan Patient Assistance Program (should I qualify). This Authorization will expire in 10 years or a shorter period if required by state law, unless I cancel it sooner by calling 1-844-424-6727 or by writing to Allergan Patient Assistance PO Box 66764, St. Louis MO 63166. I understand that cancelling my Authorization will not affect any use of my information that occurred before my request was processed.

PATIENT TERMS OF PARTICIPATION

Allergan Patient Assistance Program provides free medicines to qualifying patients. Participation in our program is free; we do not collect any fees from people seeking our assistance. Medication assistance is dependent on your ability to meet the eligibility criteria for program as determined by Allergan Patient Assistance Program. Allergan Patient Assistance Program does not have any obligation to provide the program services to you and is not liable in the provision of these services. Allergan Patient Assistance Program may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You will notify the program if your insurance or financial situation changes. If this application has been completed by a personal representative, the personal representative will provide a copy of this completed application to you.

If you are a member of a Medicare plan including a Medicare Prescription Drug plan and are qualified for program assistance, you will: (i) be eligible to obtain the medication from the program for a calendar year term (ii) not purchase this medication under your Medicare plan while enrolled in the program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during your enrollment; (iv) provide written notification to your Medicare Prescription Drug Plan, if applicable that you are receiving your medication at no cost outside of the Medicare Part D benefit.
If you have questions, want to update your information, or terminate your enrollment, please call 1-800-424-6727 or write to us at PO BOX 66764, St. Louis, MO 63166.

PATIENT PRIVACY NOTICE

Allergan Patient Assistance Program will use and disclose with authorized third parties your personal information including your financial and health information collected on this enrollment form and through participation in the program for the following purposes:
1. To determine your eligibility for the program and to provide you with related services, including transfer to a separate private or public payer program, reimbursement services, services to ship your medication, and other support services.
2. To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
3. To administer and maintain the quality of the program, including but not limited to case review, compliance checks, audit review and accounting purposes.

For additional information on how Allergan processes your personal information, please visit:
California Privacy Policy: https://www.allergan.com/privacy/ccpa
Allergan US Privacy Policy: https://www.allergan.com/privacy-and-terms/united-states

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NO FEES FOR THIS PROGRAM

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

Acuvail® (ketorolac tromethamine) ophthalmic solution	Linzess® (linaclotide) capsules
AeroChamber Plus® Flow-Vu®	Lumigan® (bimatoprost 0.01%) opthalmic solution
Alphagan® P (brimonidine tartrate) ophthalmic solution	Monurol® (fosfomycin tromethamine) oral granules
Armour Thyroid® (thyroid tablets, USP) tablets	Namenda® and Namenda XR® (memantine HCl) tablets
Avycaz® (avibactam, ceftazidime) powder	Namzaric® (memantine HCl extended-release and donepezil HCl) capsule
Bystolic® (nebivolol) tablets	Ozurdex® (dexamethasone) ocular implant
Canasa® (mesalamine) suppository	Pred Forte® (prednisolone acetate) ophthalmic suspension
Carafate® (sucralfate) oral suspension	Pylera® (bismuth subcitrate potassium, metronidazole, and tetracycline HCl) capsules
Combigan® (brimonidine tartrate/timolol maleate) opthalmic solution	Rapaflo® (silodosin) capsules
Crinone® (progesterone) gel	Rectiv® (nitroglycerin) ointment
Dalvance® (dalbavancin) lyophilisate	Restasis® (cyclosporine) ophthalmic emulsion
Delzicol® (mesalamine DR) capsules	Saphris® (asenapine maleate) sublingual tablet
Durysta® (bimatoprost) ocular implant	Savella® (milnacipran HCl) tablets
Estrace® (estradiol) Cream	Teflaro® (ceftaroline fosamil) powder for injection
Fetzima® (levomilnacipran) Extended Release Capsules and Titration Pack	Ubrelvy® (ubrogepant) tablets
Gelnique® (oxybutynin chloride 10 %) gel	Viberzi® (eluxadoline) tablets
Infed® (Iron Dextran) Injection	Viibryd® (vilazodone HCl) tablets
Lexapro® (escitalopram) tablet	Vraylar® (cariprazine) capsules
Liletta® (levonorgestrel) Intrauterine Contraceptive	Xen® sterile injector

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