← Staple RX behind completed application; additional information behind RX.

Rev. 6/17

ALLERGAN ▪ Patient Assistance Program

PO BOX 66764 • St. Louis, MO 63166 • +1 844-4AGN-PAP (+1 844-424-6727) • Fax 844-708-0036

allergan.com/pap For Product Information: Phone 800-678-1605

SECTION 1.0: LICENSED PRESCRIBER INFORMATION

First Name (Legal):	MI:	Last Name:	Professional Designation:

State License Number:	DEA Number: NPI Number:

Mailing Address:	Ste. Number:	PO Box:

City:	State:	Zip Code:

Delivery Address (must be authorized to accept prescription drugs):	Ste. number:	PO Box:

City:	State:	Zip Code:

Office Contact Name:	Phone Number:	Ext:

Attach valid prescription(s) for medication(s) or device(s) to this application.

SECTION 2.0: PATIENT INFORMATION

First Name (Legal):	MI:	Last Name:	Gender:

Phone Number:	Date of Birth:

Mailing Address:	Apt. Numb	PO Box:

City:	State:	Zip Code:

Marital Status:	Email Address:

Number of People in Household (include yourself): Are you a veteran? ☐ Yes ☐ No Have you received disability payments from SS 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: OTHER 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 a Medicare D Plan? ☐ Yes ☐ No

Do you have private prescription coverage/reimbursement? ☐ Yes ☐ No

If yes, please provide the following information regarding your primary and any secondary insurance company (attach additional sheets, if necessary):

Plan name:_____ Policy holder name: _____

Policy ID#:_____ Group #: _____

What is the **co-pay/reimbursement** under your plan for the requested medication? _____

Has your insurer denied coverage for the requested medication? ☐ Yes ☐ No

PATIENT AND LICENSED PRESCRIBER MUST SIGN & DATE THE CERTIFICATIONS

SECTION 3.0: PATIENT CERTIFICATION

I certify that I do not have the ability to pay for the drug(s) and/or device(s) requested by my licensed prescriber on the prescription attached to this application and that all information provided in sections 2.0, 2.1 and 2.3 is correct and complete. I understand that Allergan Pharmaceuticals, Inc. Patient Assistance Program ("Program") is entitled at any time to request verification of any such information which I agree to provide from me, my employer, and/or my insurer. I understand that the program may contact me for verification of my application status and receipt of the indicated drug(s) and/or device(s). I understand that if approved, I am not eligible to, and I certify that 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 insurer, and that I will not sell, trade, or distribute the Program drug(s) and/or device(s). I understand my eligibility or continued eligibility under the Program is subject to Allergan' discretion and that the Program reserves the right to modify or terminate the PAP at any time. I understand that if I am approved, my prescriber will receive a three-month supply of drug(s) or device(s) to dispense to me and that I must re-apply to the Program each time I need drug(s) or device(s).

I also understand and certify that if I am a Medicare Part D enrollee, I will not apply or claim any Program drug(s) and/or device(s) towards True-Out-Of-Pocket ("TrOOP") costs. If I am enrolled in a Medicare Part D Plan, the Program will not deny my re-application during a Medicare Part D plan year based on a change relating to availability of Part D coverage (except for LIS eligibility).

I authorize my prescriber or pharmacy to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act ("HIPAA") and regulations there under, as well as other state or federally protected person al information) to the Program or third parties engaged, as required to assist Allergan in administering the Program. I understand that as part of that process, the Program may disclose my PHI to Centers for Medicare & Medicaid Services ("CMS") (and/or CMS's authorized vendor) for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in the Program with my Medicare Part D plan. I understand that my PHI will consist of my name, address, Social Security number, income, prescription coverage, prescription for drug(s) or device(s), financial documents and insurance records and will be used for purposes of determining my eligibility to participate in the Program and to ship appropriate drug(s) and/or device(s) as prescribed by my licensed prescriber. I further understand that if my PHI is incomplete or my completed PHI does not allow me to participate in the Program that I may be notified of such. I understand that upon the furnishing of my PHI to the Program, my PHI may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the Program and will thereafter expire. 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 at the Program. 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 form and that doing so will not affect my prescriber's treatment of me or my eligibility for insurance benefits. I understand that the Program reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria, covered medications and immediate termination of assistance provided by the Program.

Patient or Legal Guardian's **ORIGINAL** Signature or Signed Notarized POA must be attached:	Date (request valid for twelve months):
X	**X**

SECTION 4.0: LICENSED PRESCRIBER CERTIFICATION

My signature certifies that I am a licensed prescriber eligible under state law, my collaborative agreement and formulary, if applicable, to prescribe, receive, and dispense the requested drug(s) and/or device(s) listed on this application, shipped from Allergan Pharmaceuticals, Inc. (Program). I further certify all information provided in section 1.0 and on the attached prescription is correct and complete and agree to submit appropriate verification of such information upon reasonable request. I agree that drug(s) and/or device(s) provided to me by the Program pursuant to prescriptions provided by me for the applicant named in 2.0 will be provided by me to such eligible applicant for his or her own use without charge. I will not otherwise use any of such drug(s) and/or device(s) or prescribe, provide, or dispense all or any portion thereof for the use of any other person. I consent that the Program or its designee may contact the applicant named in section 1.0 for verification of applicant status and receipt of the indicated drug(s) and/or device(s). I further consent that the Program may perform an on-site audit of PAP records related to the applicant named in 1.0 of this application. I understand that I am not eligible to, and I certify that neither I nor my office will: (i) seek reimbursement for any drug(s) or device(s) dispensed by the Program from any individual, government program, or third-party insurer; (ii) return any drug or device dispensed by the Program for credit; (iii) sell, trade, or distribute this drug or device; or (iv) apply any Program drug(s) or device(s) towards the applicant's Medicare Part D TrOOP (if applicable). I further understand that I cannot seek payment for an office visit from the applicant or third-party insurer when Program drug(s) or device(s) is provided to the applicant. I also understand that an individual patient's eligibility or continued eligibility under the PAP is subject to Allergan' discretion and that the Program reserves the right to modify or terminate the PAP at any time. I further understand my enrollment is subject to Allergan' discretion and Allergan reserves the right to terminate at any time.

Licensed Prescriber's **ORIGINAL** Signature:	Date (request valid for twelve months):
X	**X**

ALLERGAN PATIENT ASSISTANCE PROGRAM

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allergan.com/pap

PATIENT ASSISTANCE PROGRAM

The Allergan Patient Assistance Program ("Program") provides medication to qualifying applicants at no charge. The products available through the Program include certain products formerly supported under the Actavis, Aptalis, Forest, Merck, and Watson Patient Assistance Programs. Please see the accompanying list of the products available through this Program. If the applicant qualifies, twelve-month eligibility for the requested medication(s) or device(s) will be approved for shipment to the applicant's licensed prescriber for dispensing. Prescriptions should be written for a three-month supply of product; physicians will be able to provide 3 refills during the twelve-month eligibility period. Annual application renewal is required.

APPLYING

Applicant

- The applicant is required to complete sections 2.0, 2.1. 2.2 and 3.0 of the application. If the applicant is a Medicare Part D enrollee, he or she must have applied for and been denied the Low-Income Subsidy ("LIS") from the Social Security Administration ("SSA").
  - The applicant must print his/her legal name exactly as it appears on his or her Social Security card.
  - To apply for LIS please contact the SSA at 800-772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/. Attach a photocopy of the LIS denial letter to the PAP application.
  - Please sign and date the certification sections; signature and date are valid for 12 months.

Licensed Prescriber

- A licensed prescriber is required to complete sections 1.0 and 4.0. In addition, the same licensed prescriber must complete and attach a prescription for the requested medication(s) or device(s). If the preprinted office address on the prescription does not match the delivery/mailing address on the application form, the licensed prescriber must also attach letterhead, coversheet or a business card to verify the delivery/mailing address on the application form.
  - Please sign and date the certification section 4.0. Signature and date are valid for 12 months.

DOCUMENTS TO SUBMIT

- Application completed by the applicant and licensed prescriber.
- Prescription from the licensed prescriber who signed the application.
- Proof of monthly household income for all persons in the household must be attached. (Tax form 1040/1040EZ or most recent W-2 or 1099 Form; Monthly benefits statement, award letter or bank statement showing monthly direct deposit (Social Security, VA, etc.); Self-Employed patients must attach a copy of the most current Federal Income Tax with appropriate schedules (C and/or F)); If you have no income, a no income letter from your physician or social worker on their letterhead stating to the best of their knowledge you have no income is needed.
- A signed and notarized Power of Attorney (POA) for signatures other than the applicants' original signature.

APPLICATION PROCESSING

Please allow 4 weeks for application processing and delivery of medication(s) or device(s) to the licensed prescriber named on the application form.

- If the applicant is approved, a three-month supply of medication(s) or device(s) will be sent to the prescribers' office for dispensing.
- If the applicant is denied, the licensed prescriber and applicant will be notified by mail.
- Incomplete applications may be returned to the applicant or licensed prescriber with instructions for completion.

NO FEES APPLY TO THIS PROGRAM.

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

Medications:	
Armour ® Thyroid (thyroid tablets, USP) Tablets	Namenda XR ® (memantine HCl) Extended Release Capsules & Titration Pack
Avycaz ® (ceftazidime/avibactam) Vials	Namzaric ® (memantine hydrochloride extended-release and donepezil hydrochloride) Capsules
Bystolic ® (nebivolol) Tablets	Pylera ® (bismuth subcitrate potassium, metronidazole, and tetracycline HCL) Capsules
Byvalson ™(nebivolol and valsartan)	Rapaflo ® (silodosin) Capsules
Canasa ® (Mesalamine, USP)	Rectiv ® (nitroglycerin) Ointment
Crinone ® (progesterone gel)	Saphris ® (asenapine maleate) sublingual tablet
DALVANCE® (dalbavancin) for injection	Savella ® (milnacipran HCl) Tablets & Titration Pack
Delzicol ® (mesalamine) DR Capsules	TEFLARO® (ceftaroline fosamil) for injection
Estrace ® (estradiol) Cream	Trelstar ® (triptorelin pamoate) injectable suspension
Fetzima ® (levomilnacipran) Extended Release Capsules & Titration Pack	Ultresa ® (Pancrelipase) Capsules
Gelnique ® (oxybutynin chloride 10 % gel)	Viberzi ® (eluxadoline) Tablets
Infed ® (Iron Dextran) Injection	Viibryd ® (vilazodone HCl) Tablets & Titration Pack
Liletta ® (levonorgestrel) Intrauterine Contraceptive Device	Viokace ® (Pancrelipase) Tablets
Linzess ® (linaclotide) Capsules	Vraylar ™ (cariprazine) Capsules
Monurol ® (fosfomycin) Powder	Zenpep ® (Pancrelipase) Capsules
Namenda ® (memantine HCl) Tablets	**Device :** AeroChamber Plus ® Flow-Vu ® Mouthpiece*/ Flow-Vu ® Mask*
Namenda ® (memantine HCl) Oral Solution	

* Maximum amount for AeroChamber or AeroChamber with mask is one per applicant in a six-month period.