PO Box 66553
St. Louis, MO 63166-6553

Procter&Gamble
PHARMACEUTICALS

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

Thank you for referring your patient to our Patient Assistance Program. Attached is a copy of the application form. It may be photocopied and used for additional patients.

To be eligible for free medicine from Procter & Gamble Pharmaceuticals (P&G), a patient must be a U.S. resident, must not have affordable coverage for the prescription, and the patient's total household income must be less than 200% of the federal poverty level (FPL). If the patient is eligible to enroll in a Medicare prescription drug plan and has income below 150% FPL, the patient must document that she or he does not qualify for a Medicare drug subsidy ("Extra Help"). Note that the product provided to your patient under the Patient Assistance Program does not count toward true out-of-pocket spending (TrOOP) under the Medicare Part D prescription drug benefit.

All of P&G's oral prescription medicines are available through our program in up to a 90-day supply with up to 3 refills:

Actonel® (risedronate sodium tablets)
Actonel® with Calcium (risedronate sodium tablets with calcium carbonate tablets, USP)
Asacol® (mesalamine) delayed release tablets
Didronel® (etidronate disodium) tablets
Macrobid® (nitrofurantoin monohydrate/macrocrystals) capsules
Macrodantin® (nitrofurantoin macrocrystals) capsules

Patients must reapply every year.

APPLICATION INSTRUCTIONS FOR PATIENTS - REQUIRED

__ Fully complete 3 sections:
  __ Patient Information (Section 2)
  __ Insurance Information (Section 3)
  __ Income Information (Section 4)
__ Sign the application.
__ Attach a copy of last year's tax return or other records for proof of income. Some examples are IRS Forms 1040, 1040A, 1040EZ, W2 and 1099 Social Security Statement. If you did not file a tax return, please attach an IRS Form 4506-T, which shows that you did not file.
__ If you have Medicare and income below 150% FPL, attach a copy of the letter from Social Security that states you do not qualify for Extra Help with Medicare Part D drug costs.

For questions regarding this program or application, please call us at **1-800-830-9049**.

APPLICATION INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

__ Complete Practitioner Information Section 1. Provide phone, fax, and DEA or State License number.
__ Sign the Practitioner Certification section.
__ Have patient fully complete the Patient Information Sections 2, 3 and 4 and sign the application.
__ Complete the Prescription page of the application or attach a prescription with this information.
__ Fax or mail the application, financial documentation, and prescription to:

Procter & Gamble Pharmaceuticals Patient Assistance Program
PO Box 66553
St. Louis, MO 63166-6553
PHONE 1-800-830-9049 FAX 1-866-277-9329

If the patient is approved, the medication and a refill mailer will be sent to the patient's home within 14 days. An approval letter will also be sent to the practitioner. If the patient is denied eligibility, a letter will be sent to the patient and practitioner within 14 days.

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St. Louis, MO 63166-6553

Procter&Gamble PHARMACEUTICALS

PATIENT ASSISTANCE PROGRAM APPLICATION FORM

Procter & Gamble Pharmaceuticals is committed to improving access to our products. To qualify for free medicine, patients should not have affordable coverage for this prescription through private or public insurance. Each patient's case is handled on an individual basis.

SECTION 1 - PRACTITIONER INFORMATION (Please print clearly)

Last Name, First Name ,,	Office Contact Person
Office Street Address	
City State Zip Code	Phone ( ) Fax ( )
Professional Designation: (check one) ☐ MD ☐ DO ☐ NP ☐ PA	**State License # (or DEA#, if required)**

PRACTITIONER CERTIFICATION

I request that the Procter & Gamble Pharmaceuticals medication(s) on the enclosed prescription(s) be provided for the above-named patient who has demonstrated a medical need. To the best of my knowledge, my patient does not have affordable third party coverage for this prescription through, for example, an HMO, Private Insurance, State Pharmacy Program, Medicare, Medicaid, or Veteran's Assistance.

Practitioner's Signature **X**	**Date**

SECTION 2 - PATIENT INFORMATION (Please print clearly)

Note: Upon approval, medication will be sent to the patient address

Patient Last Name, First Name ,,	Social Security or ID Number	Patient Date of Birth / /
Patient Street Address		US Resident ☐ Yes ☐ No
City State Zip Code	Phone ( )	Gender ☐ Male ☐ Female
List any Patient Drug Allergies: ☐ N/A	Number of people in household (include self): (circle one) 1 2 3 4 5 6 7	
List any other Patient Medications:		

SECTION 3 - PATIENT INSURANCE INFORMATION

Do you have Medicaid? ☐ Yes ☐ No

Do you have Medicare? ☐ Yes (Indicate coverage below) ☐ No

☐ Original Medicare Plan ☐ Medicare Prescription Drug Plan

☐ Medicare Health Plan Without Prescription Coverage ☐ Medicare Health Plan With Prescription Coverage

Do you have prescription drug coverage? ☐ Yes ☐ No

If yes, is this prescription covered by your prescription plan? ☐ Yes ☐ No

SECTION 4 - PATIENT INCOME INFORMATION

Note: Attach Proof of Income (Examples: Federal Tax Return, IRS Form 1040, 1040EZ, 1099, Social Security or Disability Statement)

TOTAL GROSS MONTHLY INCOME	**$**

I hereby consent to allow P&GP and my physician to supply this information to any third party engaged to assist P&GP in the administration of the P&GP Patient Assistance Program (PAP). I understand that this information will be used solely to determine my eligibility for participation in the PAP and to administer the program, except as may be required or permitted by applicable law, and that P&GP reserves the right at any time for any reason to contact me and to request additional information.

By signing below, I verify that the information in this application, including all copies of documentation, is complete and accurate, and that I am authorized to sign this application. I also verify that I am not currently receiving benefits for this medication from Medicaid, Medicare, or other public or private insurance or assistance program. I acknowledge and agree that I shall not in any way report or count the value of the product provided to me under this Program as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit. I understand that P&GP and any third party engaged to assist P&GP has the right to verify my eligibility, including the right to audit any information provided. I also agree that I will contact P&GP if any of the information regarding prescription drug coverage or insurance changes. I also understand that P&GP has the right to contact me directly and to confirm receipt of medications and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation in the PAP at any time by mailing a letter to the PAP.

Patient's Signature **X**	**Date**

The patient will be contacted within 14 days regarding eligibility.

MAIL/FAX COMPLETED FORM, FINANCIAL DOCUMENTATION AND PRESCRIPTION TO
PO BOX 66553 ST. LOUIS, MO 63166-6553
PHONE 1-800-830-9049 FAX 1-866-277-9329

PO Box 66553
St. Louis, MO 63166-6553

Procter&Gamble PHARMACEUTICALS

PATIENT ASSISTANCE PROGRAM PRESCRIPTION FORM

Prescription Information
Please fill out completely

Patient Information

Please Print

Patient Name: _____

Social Security or ID Number:_____ Date of Birth: _____

C/O:_____ Phone Number:_____

Shipping Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Practitioner Information

Prescriber Name:_____

DEA#/StateLicense#:_____Phone:_____

Prescription Information

Have your prescriber complete the following information, or attach a prescription. If you attach an original prescription, make sure it includes the information below.

All information below must be completed by prescriber in order to process prescription.

Valid only for Procter & Gamble oral prescription products listed below
If you are a New York prescriber, please use an original New York State Prescription Form.

Date: _____

☐ **Actonel 5mg** ☐ **Actonel with Calcium 35mg**
☐ **Actonel 30mg** ☐ **Actonel 150mg**
☐ **Actonel 35mg**
☐ **Actonel 75mg**

Directions: _____

Qty: 90 days supply **Refills** (circle one): 1 2 3

☐ **Asacol 400mg** ☐ **Didronel 200mg** ☐ **Macrobid 100mg** ☐ **Macrodantin 25mg**
☐ **Didronel 400mg** ☐ **Macrodantin 50mg**
☐ **Macrodantin 100mg**

Directions: _____

Qty:_____ **Refills** (circle one): 1 2 3

Prescriber's Signature: _____ _____

Substitution Permitted **Dispense As Written**