PATIENT ASSISTANCE PROGRAM

PO BOX 42886 CINCINNATI, OH 45242 | PHONE: (866) 247-2228 | FAX: (513) 338-8246

PATIENT ASSISTANCE PROGRAM ELIGIBILITY AND GUIDELINES

- The application must be completed in its entirety
- FAX or MAIL the application with requested documentation to the address above
- The patient must be a U.S. Resident with a valid Social Security Number
- The patient must have a household income at or below 200% of the current Federal Poverty Level
- The patient must not have prescription insurance coverage
- Patients who meet certain rules will be able to get their prescribed medications free of charge for up to one year
- Every year, the patient must reapply, and be accepted, to continue in the program

FOR THE HEALTHCARE PROVIDER

- The application must be completed with an original signature. Stamp signatures are not accepted.
- In order to refill your patient's medication after the three month period, you must submit a copy of the original application with your signature.

FOR THE PATIENT

- The application must be completed in its entirety with an original signature and date.
- You must submit copies of your household income documentation, including but not limited to W2 Forms, Social Security Statements, or copies of your most recent pay stubs.
- You must reapply to the program annually, including the completion of a new application and current income documentation.

PLEASE NOTE: Healthcare Providers can manage the patient assistance application process online by visiting www.RxHope.com/Horizon

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PHYSICIAN INFORMATION

State License#_________________**Exp.**______________________**Physician NPI#**____________________________

Physician Name (First, MI, Last)____________________________________**Designation**____________________________

Address ____

City___________________**State**______**Zip Code**_________________**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 for this medication from any third party.

PHYSICIAN SIGNATURE____**DATE** _______________________

PRODUCT INFORMATION

Please select the medication(s) and dosage(s) needed. For RAYOS, please indicate the monthly quantity of tablets needed to achieve the desired dose (e.g. 30, 5 mg tablets for a daily dose of 5 mg or 60, 5 mg tablets for a daily dose of 10 mg):

____RAYOS® (prednisone) **1 mg** delayed-release tablets QUANTITY _________

____RAYOS® (prednisone) **2 mg** delayed-release tablets QUANTITY _________

____RAYOS® (prednisone) **5 mg** delayed-release tablets QUANTITY _________

_____VIMOVO® (naproxen and esomeprazole magnesium) **375 mg / 20 mg** delayed-release tablets QUANTITY: 60.

_____VIMOVO® (naproxen and esomeprazole magnesium) **500 mg / 20 mg** delayed-release tablets QUANTITY: 60.

_____DUEXIS® (ibuprofen and famotidine) **800 mg / 26.6 mg** delayed-release tablets QUANTITY: 90.

_____PENNSAID 2%® (diclofenac sodium topical solution) **40mg (2 pumps)** topical NSAID solution QUANTITY: 1 bottle.

A 3-month supply of medication will be shipped to the healthcare provider's office.

PATIENT INFORMATION

Patient Name (First, MI, Last)____**Date of Birth (MM/DD/YYYY)** ________________

Address____**City**_________________________**State**_____**Zip Code** ______________

Telephone____**Social Security Number** ______________________________

Number of people in your household_________________________**(include yourself, your spouse, and your dependents, if applicable) What is the total combined household income per year? $**_________________________________**per year**

Please include a copy of your most recent Federal Tax Return, Social Security Statement, or other documents that support the income amount provided above. If you have indicated no income ($0), your application may be subject to audit or request for additional documentation.

INSURANCE INFORMATION

Do you have coverage for prescription medications through (check all that apply):

☐ **Medicaid** ☐ **Private Insurance** ☐ **State Assistance Program for Medication**

☐ **Medicare A or B** ☐ **VA or Military Benefits** ☐ **Medicare Part D**

☐ **I do not have any coverage for prescription medications**

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.

PATIENT SIGNATURE____**DATE** _______________________

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