McNeil Consumer and Specialty Pharmaceuticals
Patient Assistance Program
PO Box 1015
San Bruno, CA 94066
(866) 727-4626

The following information is required to enable the Patient Assistance Program Specialists to determine eligibility for a patient. If eligibility is established, the form with **original signatures** must be sent to the above address before product can be shipped.

New Application _____ **Re-Application** _____

Section 1 – To be completed by patient or patient's family and submitted to Physician.

PATIENT INFORMATION: (Please Print Clearly)

Name of Patient

Name of Guardian (if appropriate)

Patient's Address

City State Zip

( ) ( )
Phone Number – Home Work

Date of Birth SS#

M_____F_____

INSURANCE INFORMATION

Name of Insurance Company Policy # Group #

Address

City State Zip

Phone Number Contact Person

Subscriber's Name Date of Birth

Subscriber's Relationship to Patient

Secondary Insurance Policy # Group #

Address City State Zip

( )
Phone Number Contact Person

Do these policies cover prescription drugs? _____Yes _____No

Has patient or guardian applied to public programs such as Medicaid or state drug assistance programs? _____Yes _____No

PLEASE ATTACH COPY OF PROOF OF DENIAL LETTER

FINANCIAL INFORMATION

Gross Annual Household Income and Source of Income
Salary/Wages/Unemployment $_____
Pension/Social Security $_____
SSI $_____
SSDI $_____
Other:_____ $_____
TOTAL $_____
Number of household members dependent on income stated above (include applicant) _____

PLEASE CHECK APPLICABLE BOX

Attached is a copy of my most recent federal tax return. ☐

I do not file federal taxes. ☐

Application Declaration

"I promise that the information on this form is correct and complete. If needed, McNeil Consumer and Specialty Pharmaceuticals and its Patient Assistance Program (the "program") may request and obtain information about my, or my family's income to enroll me in the Program. I understand that the program administrators reserve the right any time and without notice to modify the application form; modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time."

Please indicate your agreement with these terms by signing below.

Patient's Signature Date

Section 2 – To be completed by physician.

Name of Physician

Address

City State Zip

( ) ( )
Phone Number Fax Number

State License # DEA #

Office Contact Name

PRODUCT/COUPON DISTRIBUTION INFORMATION

Indicate special shipping instructions. (office hours available for delivery etc)

_____

Physician Services

McNeil Consumer and Specialty Pharmaceuticals Patient Assistance Program requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. This insurance company may be billed for services. No claim, however, may be made to any third party payor for payment for product provided under this program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician's Signature Date

Prescription Information

Patient's Name Date

Product Name

Sig: Signature Quantity