Strativa PHARMACEUTICALS

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PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application must be completed, signed and dated by both the Healthcare Professional and Patient.
- Patient must submit Proof of Income.
- Acceptable Proof of Income documentation includes: Federal Income Tax (form 1040 or 1040EZ) with appropriate schedules (C and/or F) or Federal Income Tax Form 1099 or Yearly benefits statement (SSA, 1099, etc), award letter or bank statements showing automatic deposit for the current calendar year or current pay stub (Require 3).

ELIGIBILITY & REQUIREMENTS

- Patient can not have prescription coverage through any Private Insurance, State or Federal Program.
- Patient's annual household income must be at or below 200% of the current Federal Poverty Level, except for MegaceES, which is set to 300% of the current Federal Poverty Level.

GENERAL PROGRAM INFORMATION

- The requested medication will ship to the Health Care Provider's office.
- Before the patient is due for a refill, the Health Care Provider and the Patient must sign and submit a new application.
- For assistance with program enrollment please contacts the Strativa Patient Assistance Program at:

1-800-589-0841

PATIENT CHECK LIST

- Patient or Patient Caregiver provided complete information as requested in STEP 1 and STEP 2? YES NO
- Patient or Patient Caregiver has and will supply required proof of income documentation? YES NO
- IF No to proof of income, please contact Strativa Patient Assistance Support Line at: **800-589-0841**
- If Patient has insurance coverage, please provide a copy of your insurance card (both sides).

HEALTHCARE PROFESSIONAL CHECK LIST

- Healthcare Professional provided complete information as requested in STEP 3 and STEP 4? YES NO

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Patient Assistance Program
P.O. Box 1475 Morristown, NJ 07962

Phone: 800-589-0841
Fax: 973-644-3308

STEP 1 - PATIENT INFORMATION - TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

Patient First Name: MI: Patient Last Name:

Address:

City: State: Zip: Gender: Male Female Marital Status: S M W D

Phone: Date of Birth: (MM/DD/YYYY) Social Security #:

Are you a U.S. Resident? Y N Are you a Veteran? Y N Are you Disabled? Y N

Gross Annual Household Income: Number of Persons in Household:

Contact Name: (If other than Patient) Relationship to Patient:

Proof of Income Documentation is required for this program. Please select the documents you intend to submit.

Federal Tax Return Social Security Income Bank Statements/Paycheck Stubbs (minimum of 3)

Other:

STEP 2 - PATIENT INSURANCE INFORMATION - TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

What type of insurance coverage do you have? **NO Insurance Coverage** Check Here:

Medicare Part A Medicare Part D Medicare Advantage Medicaid

Medicare Part B Employer Other

For each insurance policy you have, please attach a copy of both sides of your insurance card and fill in the following:

Primary Insurance Name:	Secondary Insurance Name:
Phone Number:	Phone Number:
Policy ID:	Policy ID:
Group Number:	Group Number:

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford 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 otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize Strativa Pharmaceutical, Inc. to obtain and disclose information from physicians, insurance companies and others as necessary to verify the information provided on this application.

Patient Signature Date / /

STEP 3 - PROVIDER INFORMATION - TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR OFFICE

DEA Number: (if applicable) NPI Number: Expiration Date:

State License Number: Expiration Date:

Physician First Name: Physician Last Name: Prof Designation:

Address:

City: State: Zip: Office Contact:

Telephone: Ext: Fax: Physician Email (Optional)

STEP 4 - PRESCRIPTION INFORMATION - THIS IS THE PRESCRIPTION; NO ADDITIONAL PRESCRIPTION IS NEEDED

Product	Dosage	Administration	Distribution	Refills
Megace ES	625 mg/5 ml		30 Day Supply	1 2 3
Nascobal	One Spray/500 mcg		60 Day Supply	1 2 3
Oravig	50 mg Buccal Tablets		14 Day Supply	1 2 3
Zuplenz	4 mg Oral Soluble Film		10 Day Supply	1 2 3
Zuplenz	8 mg Oral Soluble Film		10 Day Supply	1 2 3

I verify that the information provided is complete and accurate to the best of my knowledge. Strativa Pharmaceutical, Inc. reserves the rights to request additional information if needed and to change or discontinue this program at any time without notice. By signing this form, I certify that I am prescribing the aforementioned medication for a patient participating in the patient assistance program. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Healthcare Provider Signature Date / /