**Form May Be Duplicated**

**ALCON CARES, INC. Tel: 800-222-8103 Fax: 800-554-2660**

Alcon Cares, Inc. ("ACI") is a Foundation offering a voluntary public service program which provides medication to qualified individuals at no charge. Each request is subject to approval and fulfillment is based upon current available resources. The Foundation reserves the right to modify or discontinue this program at any time. These products are not to be sold, traded or used for any other purpose.

Reset Form

| New ☐ Date: | Renewal ☐ Date: |
|---|---|

**INSTRUCTIONS:**

**Patient/Legal Guardian:** Complete Section 1. Please include **COPIES** of the most recent Federal Income Tax return or other proof of income for you and those in your household along with this application.

**Healthcare Provider** -- Complete Section 2

**FAX TO: 800-554-2660 OR MAIL TO: Alcon Cares, Inc. - TB3-4 • 6201 South Freeway • Fort Worth, TX 76134-0450** Incomplete requests cannot be considered and will be returned.

## Section 1: PATIENT INFORMATION

| | | |
|---|---|---|
| NAME (FIRST) | (LAST) | PHONE |
| STREET ADDRESS | | SSN# |
| CITY | STATE | ZIP |
| DATE OF BIRTH (MM/DD/YYYY) | | US CITIZEN ☐ YES ☐ NO |
| MARITAL STATUS: ☐ SINGLE | ☐ MARRIED | ☐ WIDOWED |
| # OF PERSONS SUPPORTING HOUSEHOLD | | |
| # OF PERSONS DEPENDENT UPON HOUSEHOLD INCOME | | |

## INSURANCE INFORMATION

**If the patient does not have any public or private insurance, please check this box:** ☐

If the patient does have medical insurance or coverage of any kind, please indicate below:

Insurance Company: _____ Telephone #: _____

Plan Name: _____ Policy ID #: _____

Is the patient eligible for Medicare? ☐ **Yes** ☐ **No**

If no, will the patient be eligible for Medicare within the next 12 months. ☐ **Yes** ☐ **No**

If yes, please provide date patient will be Medicare eligible __ / ____ / ____ (Month/Day/Year).

Medicare Policy # _____

Is the patient enrolled in a Medicare prescription drug plan? ☐ **Yes** ☐ **No**

Insurance Company: _____ Telephone #: _____

Plan Name: _____ Policy ID #: _____

Is the patient eligible for the Low Income Subsidy for Medicare Part D?

☐ **Yes** ☐ **No** ☐ **Don't Know, Application Pending**

Is patient eligible for Medicaid? ☐ **Yes** ☐ **No**

If yes, is the patient eligible for prescription drug benefits? ☐ **Yes** ☐ **No**

## FINANCIAL INFORMATION

Please include **COPIES** of the most recent Federal Income Tax return or other proof of income for you and those in your household. **Please check this box if you did not file a tax return:** ☐

| TOTAL ANNUAL INCOME (GROSS): | $ |
|---|---|

**Asset Valuation ( For Medicare Patients Only):**

Value of Assets: **$**_____ **Include:** checking & savings accounts, certificates of deposit, stocks & bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash right now. **Not included:** your home, vehicles, burial plots or personal possessions.

**Patient Authorization:** I certify that I have provided my prescribing physician with all of the necessary consents authorizing him/her to release my health information to ACI. Unless revoked, this authorization will remain in effect for the duration of my participation in the program.

**Declaration Regarding Incurred Drug Expenses:** I understand and agree that the value of the free drugs provided to me pursuant to this program does not count as true out-of-pocket spending ("TrOOP") under Part D of the Medicare program or any other prescription drug plan. I further agree that I will seek no reimbursement for any drugs obtained under this program.

**Applicant Declaration Regarding Change in Insurance Coverage:** I understand that ACI policy requires individuals with access to medicines through an affordable benefit to seek access through that benefit. As such, I promise that I will notify Alcon Cares, Inc. within 30 (thirty) days by mail at, Alcon Cares, Inc. - TB3-4 • 6201 South Freeway • Fort Worth, TX 76134-0450, OR by telephone at 800-222-8103, OR by fax at 800-554-2660 if there is any change in the status of my eligibility to obtain any drug(s) that I will receive under this Program through any other resource, including Medicare, at any time during my participation in this Program.

**Applicant Declaration Regarding Accuracy and Completeness of Information**

I promise that the information on this form is correct and complete. If needed, Alcon Cares, Inc. may request and obtain additional information about my or my family's income to enroll me in the Program.

**Patients may call 800-222-8103 to check the status of their application.** Please indicate your agreement with these terms by signing below.

**Patient's Signature: _____ Date: _____**

**Section 2: HEALTHCARE PROVIDER SECTION**

| | | | |
|---|---|---|---|
| THERAPEUTIC LICENSE# | | STATE | |
| Facility Name | | Facility Contact Name | |
| Healthcare Provider Name (First) | | (Last) | |
| Street Address | | | |
| City | State | Zip | Phone |
| Business Hours | | Office Contact Name | |
| Tax ID # | Medicare Provider # | | |

**Requested Product(s) (This is the PRESCRIPTION, please print):**

| **Product(s)** | **Strength** | **Dosage** | **Duration** |
|---|---|---|---|
| | | | |

For over-the-counter product(s), do the product(s) need to ship to the patient's address. ☐ **Yes** ☐ **No**

I certify that the information in this Section is correct and I understand that the medication will be sent at no charge, and I will not submit any claim for reimbursement to any public or private third party payor (e.g., Medicaid, Medicare, private insurance, etc.) for products received on behalf of a qualifying patient under this program. I further certify that I have obtained all necessary consents authorizing me to release protected health information to ACI. **I understand that participation in this program is neither connected to the marketing of Alcon products, nor requires the purchase of Alcon products.** I further understand that these goods may not be sold or traded and may not be returned for credit. My signature below confirms that I agree to these terms as further articulated in the Guidelines attached and that there is a valid medical need for this patient's prescription.

**Healthcare Provider's Signature: _____ Date: _____**

**If required, collaborating Physician's Name: _____**

**Therapeutic License #: _____**

# Alcon Cares, Inc. - Guidelines

The program is open to any private patient of a U.S. licensed healthcare provider who cannot afford their medication and does not have prescription insurance coverage, and does not qualify for local, state or federal prescription programs unless such programs are documented to cause a financial hardship for the patient. Eligibility is based on several factors including income limits that are tied to U.S. Government Census Bureau figures and type of insurance coverage. Because the guideline documents are large and complex we do not give them out over the phone. Relevant U.S. Government Census Bureau information may be found in public sources such as the internet or the library. However, patients should qualify for the income test at 200% (two times) the current year's poverty level under the number of persons living in a household. Current HHS guidelines can be found at http://aspe.hhs.gov/poverty/

We require the healthcare provider to complete his/her section of the application on behalf of his/her patient. The healthcare provider also agrees not to proactively market the program beyond communicating its existence and availability to his/her patients. There are no product purchase requirements for participation in this program.

An approved application is good for one year. If a patient has been denied, a letter will be sent to the patient stating the reasons for denial and the action necessary to resubmit the application. In those cases where the required criteria are not met, the application should not be resubmitted. Because we only ship up to a **SIX-MONTH** supply, patients must coordinate with their healthcare provider in order to receive the second **SIX-MONTH** supply. If there are no changes to the application or the product(s) requested from the first **SIX-MONTH** supply, the healthcare provider can check renewal on page 1 of the original application, put a date in the renewal box and fax or mail in pages 1 and 2 of the original application. If there are changes to the product(s) needed, the healthcare provider needs to print off or copy an additional blank page 2 of our application. Fill out the product(s) section and sign it. On the original page 1, check the renewal box and fill in the date. Fax or mail the new page 2 with page 1 and 2 of the original application.

**There are no charges at all to patients or healthcare providers for access to this program.** We use social security number to verify financial and insurance qualifications. A separate unique number will be assigned to each patient participating.

The program's guidelines are based upon the manufacturer's ability to donate product. We would like to accommodate all requests, but we cannot. Our criteria, guidelines, and limits help us to meet the needs of those patients most in need.

To inquire, check the status of an application or to get the latest application, call the program's number at 1-800-222-8103. Patients may also contact their healthcare provider, who will be able to obtain our application, which will screen for eligibility based upon income, assets, household information, medical information, and other factors. (If requested, an application can be sent directly to the patient.)

- Complete all appropriate sections of the application.
- Incomplete or illegible applications will not be honored.
- **Fax** completed requests to **800-554-2660** or **mail** completed requests to **Alcon Cares, Inc**. • **TB3-4 • 6201 South Freeway • Fort Worth, TX 76134-0450**.

If no follow-up information is required and the application is approved, we will ship the approved medication within ten business days of receiving the application. The shipper will deliver the medication in 1-3 days from the date that we ship the medication.

The medication will be shipped via freight carrier to the healthcare provider's office.

- **Glaucoma medications** will be provided for the patient through a U.S. licensed healthcare provider for as long as the healthcare provider deems it medically and financially necessary.
- **Prescription Pharmaceuticals** other than glaucoma medications will be provided for the length of the treatment plan determined by the healthcare provider.
- **Over-the-counter products** recommended by the healthcare provider for chronic eye conditions will be provided for but may be limited to a maximum of **SIX-MONTH** supply per year.

By completing this application, the patient understands that if accepted into the patient assistance program it will be based upon the information that they have entered onto this form in good faith. Should the patient change their healthcare provider before the term of enrollment in the program terminates, they agree to complete a new application with the new healthcare provider and submit it to Alcon Cares, Inc. to ensure continued participation without interruption.

Power of Attorney is permissible, but documentation must be provided to ACI when the patient is physically unable to sign the application. Witness of signature by healthcare provider office personnel is permissible when the patient has trouble signing their name and the healthcare provider office personnel sign that they witnessed the patient signing their name.

Any questions related to Medicare Part D prescription coverage as it relates to products offered by Alcon Cares, Inc should be directed to our staff at **800-222-8103**.