Arestin® minocycline HCl 1mg MICROSPHERES

Patient Eligibility Form

Arestin® RX ACCESS

Copay Assistance Program

Date:

Phone: 1-855-684-7481 Fax: 1-855-630-9783

You may be eligible to save through the ARESTIN® Copay Assistance Program.*
Up to $1,500.00 in copay assistance.*
Offer Restrictions and Eligibility Requirements below.

Patient Name: Date of Birth:

Prescriber First & Last Name:

Street Address: City: State: Zip:

*Offer Restrictions and Eligibility Requirements

- The offer is effective starting August 31, 2015 thru December 31, 2015. The offer is only valid for patients with private insurance. Cash-paying patients or discount card programs are not eligible. Commercially insured patients whose insurance does not cover ARESTIN® (minocycline HCl) Microspheres, 1 mg will pay more.
- **Offer is not valid for prescriptions being fully or partially reimbursed by Medicaid, a Medicaid drug benefit plan, or other federal or state programs (such as medical assistance programs).** By using this offer, you agree that you will not submit a claim for the prescription to a government payer, such as Medicare or Medicaid.
- The patient is responsible for reporting receipt of this offer to any health insurer, health plan, or third-party payer as may be required. The use of this offer is subject to applicable state and federal law.
- This benefit can be used only for an ARESTIN® prescription filled by Accredo Health specialty pharmacy and dispensed to the dental office on behalf of the patient as authorized below.
- Patient must be at least 18 years of age.
- Offer good only in the United States through the ARESTIN® Rx Access program. This offer is not valid where otherwise prohibited by law, taxed, or otherwise restricted. Not valid with other offers. No cash back.
- Maximum reimbursement limits apply. If you receive coverage through a health savings account (HSA) or similar arrangement, it is the patient's responsibility to know how claims are processed and understand that amounts paid by the third party for your ARESTIN® prescription may be deducted from your benefits limit automatically.
- OraPharma, Inc. and Valeant Pharmaceuticals reserve the right to rescind, revoke, or amend this offer without notice.

By signing below you are indicating that you meet the terms and conditions set forth above and Accredo Health Group has your consent to ship the medication directly to your prescriber's office.

Patient Signature: _____ **Date:** _____