AUXILIUM

Testim® 1% (testosterone gel) CIII
Patient Assistance Program Application

40 Valley Stream Parkway ♦ Malvern, PA 19355 ♦ 1-800-454-1467 Case Number: _____

Section 1: Healthcare Provider (*This section must be completed and signed by the Health Care Provider*)

Name/Professional Designation: _____

DEA Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

DEA Number: _____ Expiration Date: _____

State License Number: _____ Expiration Date: _____

Diagnosis: _____ Is the patient currently on testosterone replacement therapy? Yes No

Please note that an original signed prescription will be required every six months.

Healthcare Provider Certification: *I request medication be provided and dispensed via my office to the patient listed below, who has certified to me that he/she is a resident of the United States, meets the income requirements, is not eligible for any third-party payment for this medication, and has been prescribed this medication for an indication stipulated in the product label. I confirm that I have read the exclusion criteria for the use of the product and to the best of my knowledge, this patient should not be excluded from this medication. These medications will not be offered for sale, trade, or barter nor returned for credit or billed to Medicare, Medicaid or any third party for reimbursement.*

Original Signature of licensed healthcare provider: _____ Date: _____

Section 2: Patient (*This section must be completed and signed by the patient.*)

Patients participating in Medicare Part D or have government or private insurance that would cover all or part of the cost of Testim are not eligible to participate in this program.

√ Note: **ONLY male** patients are eligible to apply for this program.
√ Remember to attach an original signed prescription from your physician.
√ Remember to attach a **SIGNED** copy of the most recent year Federal Tax Return (Form 1040, 1040EZ, etc).
√ If you did not file a tax return, please process IRS FORM 4506 and forward the IRS confirmation statement to Auxilium.
√ Six months of product are shipped directly to the physician noted above.
√ ***Patients must reapply annually.***

Check only one:
○ Household income is $18,000 or less for a single person
○ House income is $24,000 or less for a couple (2 people)
○ Family household (greater than 2 people) income is $32,000 or less.

Name: _____Phone Number:_____

Address (No P.O. Box): _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: _____ Number of dependents in your household: _____ (Including yourself)

Case Number: _____

Applicant Declarations: *I hereby request and authorize my physician, named above, to release to Auxilium, or their parties contracted by Auxilium in connection with this program, all information regarding my health and treatment pertaining to the medication. I further authorize Auxilium to review the necessary documents to affirm my financial eligibility for their Patient Assistance Program. I understand that information provided to Auxilium, pursuant to this authorization, will not be protected under the Health Insurance Portability and Accountability (HIPAA) Act, and therefore may be re-disclosed. However, Auxilium will use and disclose such information solely to assist with the assessment of my eligibility for and enrollment in the Auxilium Patient Assistance Program, to account for my withdrawal if I decide to stop participating in this program, and/or as required by law. I understand that this authorization is not a condition for treatment and does not guarantee eligibility into or free medication from the Auxilium Patient Assistance Program.*

In the event that I am eligible for the Auxilium Patient Assistance Program, I understand that I shall receive medication for six months (at specified intervals) without cost to me via my physician. I further understand that I may reapply for additional prescriptions as long as my physician continues to prescribe the medication and I continue to qualify for this assistance. I understand that Auxilium may at any time discontinue or change this assistance, which I accept. ***I certify that I do not have the ability to pay for this medication, earn less than the minimum allowable income for participation, am a resident of the United States, have no government or private insurance that would cover the full or partial cost of this medication, and that paying for this medication would cause me severe financial hardship.*** *I attest that the information I have provided is accurate and complete.*

Original Patient Signature: _____ Date: _____

By providing a signature below, I hereby certify that I do not participate in Medicare Part D. (Provision of false or misleading information is in direct violation of government regulations)

Original Patient Signature: _____ Date: _____