✍***Practitioner must attach a prescription (brand name only)***
✍***Patient must attach most recent Federal tax return***

Biovail Pharmaceuticals, Inc.
Patient Assistance Program
P.O. Box 836
Somerville, NJ 08876
(866) 268-7325

Patient Section*	**The patient or his/her guardian must complete this section.**
NAME:	**SS#**
ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
DATE OF BIRTH:	**PHONE NUMBER:**
Does the patient have or qualify for prescription coverage in any government programs? **Yes ✍ No ✍** ***(This includes Medicaid, Veteran's Administration and any other state or local program.)***	
Is the patient enrolled in Medicare Part D? **Yes ✍ No ✍**	
Does the patient have prescription coverage in any private program? **Yes ✍ No ✍** ***(This includes coverage through any private insurance plans, HMOs, or PPOs.)***	
Is the patient a legal U.S. resident? Yes ✍ No ✍	
What is your total <u>ANNUAL</u> household income (including social security and pension benefits?) **$_____**	
How many residents are there in your household? Please circle: 1 2 3 4 5 6+	

***IF ALL INFORMATION IS NOT CLEARLY AND COMPLETELY FILLED OUT, THIS FORM WILL NOT BE PROCESSED.**

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for medication. I authorize Biovail and its agents to use my personal identifying information for the purpose of my participating in the Biovail Patient Assistance Program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I understand that Biovail reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the Biovail Pharmaceuticals, Inc. Patient Assistance Program and authorize the use of my Social Security number for identification purposes and record keeping.

_____ _____
Original Signature of Patient or Legal Guardian (No photocopies) **Date**

Licensed Practitioner Section* **This must be completed by the practitioner before submission can be completed.**	
NAME:	
PROFESSIONAL DESIGNATION (MD, DO, ECT.):	
OFFICE ADDRESS: ***(No. P.O. Box)***	
CITY:	**STATE:** **ZIP CODE:**
DEA#:	***(If you do not have a DEA#, attach a copy of your state license)***
CONTACT PERSON IN OFFICE:	
OFFICE PHONE #:	**OFFICE FAX #:**

PRODUCT REQUESTED: **ZOVIRAX CREAM ✍** **VASOTEC ✍** **CARDIZEM ✍**
ZOVIRAX OINTMENT ✍ **VASERETIC ✍** **CARDIZEM CD ✍**

I verify that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I have read, understand and agree to all of the above. I understand that Biovail reserves the right to modify or terminate this program at any time. My signature certifies that goods received from Biovail are for the use of the above patient only. These goods will not be sold nor offered for sales, trade or barter and will not be returned for credit. I understand that Biovail reserves the right to recall the product when necessary.

_____ _____
Original Signature of Licensed Practitioner (No stamped signatures or photocopies) **Date**

IMPORTANT: Incomplete forms will not be processed! They will be returned to either the patient or the practitioner. Biovail will make every effort to grant aid when needed. This program is limited to available resources and may be discontinued or revised at any time.