BRADLEY PHARMACEUTICALS, INC.

Indigent Patient Program Application

INSTRUCTIONS:

The physician must complete the application form attached. This form must be sent to Bradley along with the prescription.

THE FOLLOWING GUIDELINES MAY BE USED IN DETERMINING ELIGIBILITY:

1. An annual income of less than $25, 000 for a family of two
2. All applications will be reviewed within the established criteria on a case by case basis
3. Patients must be a resident of the United States
4. All alternative funding sources must have been investigated.
5. All require information must be provided for consideration of eligibility.
6. Patient may be approved by exception if extreme circumstances exist.

PROCEDURE:

- Physician must complete and sign an application, including a prescription for a supply of up to 90 days.
- The patient's physician should include the following motion clearly written on the prescription:
  - Prescription for indigent
- The prescription should include the physicians:
  - State license number
- The application can be faxed to 877-223-3742 or
  - Mailed to: Bradley Pharmaceuticals, Inc.
    383 Route 46 West
    Fairfield, NJ 07004
    ATTN: Indigent Patient Program
- Once approved, the request is forwarded to Bradley's Customer Service Department for completing the order and mailing to the physician.
- All medications are sent directly to the physician. A second 90-day supply may be obtained if the patient's financial status has not changed, and the patient's symptoms continue.

Please have your physician complete the attached form

BRADLEY PHARMACEUTICALS, INC.

INDIGENT PATIENT CERTIFICATION FOR

APPLICATION FOR PATIENT ELIGIBILITY

PATIENT NAME: _____ DOB: _____

PATIENT ADDRESS: _____

CITY, STATE, ZIP _____

TELEPHONE NUMBER: (_____) _____

SSN: _____ ANNUAL INCOME: _____

APPLICATIONS WILL NOT BE PROCESSED WITHOUT THE ABOVE SECTION FILLED OUT COMPLETELY

PHYSICIANS CERTIFICATION

I the undersign, certify the above information to be true, confirm that this patient is indigent, is a US citizen and has no other means of obtaining:

_____ (product)

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (typed) _____

PHYSICIAN'S ADDRESS: _____

CITY, STATE, ZIP _____

PHYSICIAN'S PHONE NUMBER: (_____) _____

PHYSICIAN'S STATE LICENSE NUMBER: _____

DATE APPLICATION COMPLETED: _____

Fax completed application and prescription to : 1-877-935-0073

Or mail to:
Bradley Pharmaceuticals, Inc
att: Indigent Patient Program
383 Route 46 West
Fairfield, NJ #07004