Medac Pharma
Patient Assistance Program Application

CORE CONNECTIONS
Coverage, Resources and Education

Application Instructions

Patients wishing to be considered for eligibility must submit a completed application along with:

❑ Original valid prescription(s) with physician signature ❑ Any other applicable documentation

Only faxes sent from the prescribing physician's office along with a physician fax cover sheet and fax banner can be accepted.

Section 1. Prescribing Healthcare Provider Information:
All physician information must be completed.

Section 2. Patient Information:
All patient information must be completed. All fields are required.
one of the following that apply.

Section 3. Insurance Information:
Patients must complete this section.
**If the patient has applied for the Medicare Part D Low Income Subsidy through the Social Security Administration within the past year and has been denied, please attach a copy of the denial letter.

Section 4. Patient Attestation and Signature (required)
Original Patient signature is required for eligibility determination.
*Medications available on the program may change from time to time.

Financial Information

List all sources (gross monthly amounts):

Salary/Wages: $ _____

Social Security: $ _____

Disability: $ _____

Pension/Retirement: $_____

Alimony/Child Support: $ _____

Unemployment/Work Comp: $ _____

Total Gross Household Monthly Income: $_____

Total Patient Household Assets: $ _____
(excludes first home and car)

Insurance Information *(Include front and back copy of insurance card, if applicable)*

Private Prescription Drug Coverage?
❑Yes ❑No

Do you have VA Benefits?
❑Yes ❑No

AIDs Drug Assistance Program?
❑Yes ❑No

Medicare Part A? ❑Yes ❑No
Medicare Part B? ❑Yes ❑ No
Medicare Part D? ❑Yes ❑No

Have you received a denial letter for Low Income Subsidy application?
❑Yes ❑No
If yes; please attach a copy with your application.

Medicaid? ❑Yes ❑No

Elderly State Drug Assistance?
❑Yes ❑No

Fax completed form to (800)481-3325
Phone (855)33MEDAC (855-336-3322)

medac PHARMA

Medac Pharma
Patient Assistance Program Application

CORE CONNECTIONS
Coverage, Resources and Education

Prescribing Healthcare Provider Information –
Products will be shipped directly to patient's home unless otherwise directed by prescribing healthcare provider.
Physician Information (For home delivery, fax or attach a prescription with dosage, no. of refills and list of current medications)

Physician Name: _____ DEA/State License #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Information

First Name: _____ MI: ___ Last Name: _____ Sex: ❑M ❑F

Email: _____ SSN/ID No: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Number of dependents in household (including self): _____ US Resident? ❑Yes ❑No _____

Are you a Veteran of the US Armed Forces? ❑Yes ❑No

Have you received disability payments from Social Security for more than 24 months? ❑Yes ❑No

Diagnosis: _____ Date of Diagnosis: _____

Allergies: _____

Other Medications: _____

Patient Attestation And Signature

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize Medac Pharma, Inc. to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application although Medac Pharma, Inc. is not obligated to verify any of the information contained in Section 1 above or confirm other medications that I am taking.

Original Signature of Patient or Legal guardian (Required to process application)

_____ Date: _____

Prescription Information: *NY prescribers – please submit prescription on an original NY State prescription blank;*
TN prescribers – quantity must be written in both numerals and words. Example: 3 (three) doses

Patient Name (Required. Please print legibly): _____		Gender: ❑Male ❑Female Date of Birth: _____	
Medication	Strength	Directions	Quantity/Refills
Rasuvo (Methotrexate Inj. SC) , carton of 4 auto injectors	❑7.5 mg ❑10 mg ❑12.5 mg ❑15 mg ❑17.5 mg ❑20 mg ❑22.5 mg ❑25 mg ❑27.5 mg ❑30 mg	Inject every week as directed	_____ Quantity _____ Refills
Shipment Instructions: Rasuvo is shipped to the patient directly. If you prefer to have the product shipped to the Provider's office instead, please indicate here Original Signature of Prescribing Healthcare Provider (Required to process application) _____ Date: _____			❑ Ship to Provider's Office

Fax completed form to (800)481-3325
Phone (855)33MEDAC (855-336-3322)

medac PHARMA

Medac Pharma
Patient Assistance Program Application

CORE CONNECTIONS
Coverage, Resources and Education

Patient Certification And Authorization To Disclose Information

Authorization to Disclose Information

I authorize the CORE Connections Program, Medac Pharma, their agents, and third-party contractors or their service providers authorized to administer the CORE Connections Patient Assistance Program to:

- Use the information that I provided on the Patient Assistance Program application form to determine my eligibility for and assist with my continued participation in the Patient Assistance Program.
- Use my Social Security number to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process.

I understand that:

- I may refuse to sign this form, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from the CORE Connections Patient Assistance Program.
- Once I provide the information as described above to the CORE Connections Program, Medac Pharma, the agents, and third-party contractors or their service providers working on their behalf pursuant to this authorization, federal privacy laws may not prevent further disclosure of this information.
- I may receive a copy of this form at any time by contacting the CORE Connections Program at 1-855-336-3322 and I may revoke it by mailing a revocation to the CORE Connections Program, 4500 Progress Blvd, Louisville, KY 40218.
- A revocation must be in writing and is not effective to the extent that action has already been taken based on this authorization.

Patient Certification

I certify that:

- The information I provided on the CORE Connections Patient Assistance Program application is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Rasuvo that I receive from the CORE Connections Patient Assistance Program.
- I will notify the CORE Connections Program within thirty (30) days if my financial status or health insurance coverage changes.
- I will not sell, trade, or distribute Rasuvo provided to me by the CORE Connections Patient Assistance Program.

I understand that completing this application form is not a guarantee of eligibility for the CORE Connections Patient Assistance Program. I also understand that Medac Pharma may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year.

I understand that if I am currently enrolled in a Medicare Part D plan, I cannot utilize my Part D plan benefits for products received through the CORE Connections Patient Assistance Program for the duration of my enrollment. Any medication I receive through the CORE Connections Patient Assistance Program will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D.

Signature of Patient or Personal Representative	Name of Patient or Personal Representative	Dated

Description of Personal Representative's Authority to Sign for Patient (Attach documents which show authority)