EGRIFTA Assist®
P.O. Box 390
Somerville, NJ 08876
Toll Free: 1-844-EGRIFTA® or 1-844-347-4382 / Fax: 1-855-836-3069

INSTRUCTIONS for EGRIFTA® Patient Assistance Program

How to Apply:

Patient Instructions:

- ❑ Please verify that your physician has completed a Statement of Medical Necessity for EGRIFTA® along with your HIPAA authorization form.
- ❑ Complete and sign this form.
- ❑ Attach copy of most recent Federal tax return.
    - **If you do not file a Federal tax return, please attach other proof of yearly household income (such as W-2, 1099, unemployment award letter, social security, disability or pension statement) for everyone living with you.**
    - **If you have no income, you must attach a letter from the physician or social worker on company letterhead attesting to the best of their knowledge you have no income.**
- ❑ Mail (1) form and (2) copy of proof of income to: EGRIFTA® Patient Assistance Program, P.O. Box 390, Somerville, NJ 08876, or fax to 1-855-836-3069.

Who Can Enroll (Program Eligibility):

- ❑ Patient must be a legal resident of the United States.
- ❑ Patient cannot have any private outpatient drug coverage for EGRIFTA®, such as an HMO or PPO plan.

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FORM for EGRIFTA® Patient Assistance Program

Patient Information

Name _____ **Patient Gender:** ☐Female ☐Male

Address _____ **Marital Status:** ☐Single ☐Married ☐Widowed

City _____ **State** _____ **Zip** _____ **Birth Date:** _____

Phone # (____) _____ **SS #:** _____

EMAIL: _____ **Are you are resident of the US:** ☐ Yes ☐ No

Patient Representative For Purposes of Program (if applicable)
I permit the EGRIFTA® Patient Assistance Program to speak and write to the following person(s) about this form, and I permit the person(s) to sign any documents related to the Program on my behalf:

Name: _____ **Relationship:** _____ **Phone:** _____

Financial Information

Total household income $: _____ **Total household size:** _____

Please be sure to attach any of the following:

- **Most recent income tax return**
- **Annual Social Security Payment Letter**
- **Monthly Pay stub (within the last two months)**
- **Bank Statement showing automatic deposits for the current year**

Insurance Information

Do you have public or private insurance? ☐ **Yes** ☐ **No**

If yes, please provide the following and provide copy front and back of insurance card:

Name of insurance company: _____

ID#: _____ **Policy#:** _____ **Phone#:** _____

Do you have Medicaid/Medicare? ☐ **Yes** ☐ **No**
Are you Medicare Part D enrolled or eligible? ☐ **Yes, enrolled** ☐ **Yes, eligible** ☐ **No**
Are you enrolled in a Medicare Part D prescription drug plan? ☐ **Yes** ☐ **No**
Do you have other State/Government funded coverage (ADAP, SPAP)? ☐ **Yes** ☐ **No**

I attest that the above information is complete and accurate. I attest that I have no or insufficient prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. I understand and agree that PAP medication received will not count toward my true-out-of-pocket costs (TROOP) as defined under the Medicare Modernization Act. I understand that the PAP medication will be shipped to my physician for my pick-up or will ship directly to my home and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the PAP medication to any third party, including my Medicare Part D Plan. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**