GTx, Inc. Patient Assistance Program
P.O.Box 8203
Somerville, NJ 08876
Phone (866)325-8231
Fax (866)694-2546

PATIENT SECTION* **(Patient or legal guardian must complete this section.)**		
NAME:	SOCIAL SECURITY#:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	PHONE NUMBER:	

DOES THE PATIENT HAVE OR QUALIFY FOR PRESCRIPTION COVERAGE WITH ANY GOVERNMENT PROGRAM, INCLUDING MEDICAID, VETERAN'S ADMINISTRATION OR ANY STATE OR LOCAL PROGRAM?	YES ? NO ?
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE WITH MEDICARE PART D?	YES ? NO ?
IF YES, IS FARESTON COVERED ON THE PATIENT'S MEDICARE PART D PLAN?	YES ? NO ?
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE IN ANY PRIVATE PROGRAM , INCLUDING AN HMO OR PPO?	YES ? NO ?
IS THE PATIENT A U.S. RESIDENT?	YES ? NO ?
WHAT IS THE PATIENT'S TOTAL **ANNUAL** HOUSEHOLD INCOME INCLUDING SOCIAL SECURITY & PENSION BENEFITS? $ _____	
HOW MANY RESIDENTS ARE IN THE PATIENT'S HOUSEHOLD? (Check box)	1 ? 2 ? 3 ? 4 ? 5 ? 6+ ?

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to GTx, Inc. and its agents, all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the GTx, Inc. Patient Assistance Program. I also authorize GTx, Inc. and its agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this 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 verify that the information provided in this application is complete and accurate and I have insufficient financial resources to pay for the prescribed therapy. I understand that GTx, Inc. reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize GTx, Inc. to use my Social Security number for identification purposes and record keeping only.

Patient or Legal Guardian's Signature Date

LICENSED PRACTITIONER SECTION* (**Licensed practitioner must complete this section.)**		
NAME:	PROFESSIONAL DESIGNATION: (MD, DO, etc.)	
OFFICE ADDRESS: *(No P.O. Box)*		
CITY:	STATE:	ZIPCODE:
PHONE #:	FAX #	
DEA#:	*(If you do not have a DEA# **attach** a copy of your state license)*	
CONTACT PERSON IN OFFICE:	OFFICE PHONE #:	

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that GTx, Inc. reserves the right to modify or terminate this program at any time. Furthermore, my signature certifies that the product will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that GTx, Inc. reserves the right to recall the product if necessary.

Original Signature of Licensed Practitioner (No stamped signatures) Date

2008