Kowa Pharmaceuticals America, Inc.
KPAssist, Patient Assistance Program
Administered by : Truax Patient Services
602 Beltrami Ave NW. Suite 105, Bemidji, MN 56601
Phone: (877) 438-9759 Fax: (877) 438-9759

Dear Applicant,

Thank you for your interest in the Kowa Pharmaceuticals America, Inc. KPAssist, Patient Assistance Program. Enclosed you will find the application form you had requested.

To participate in our program, it is important that you complete all requested information and sign where indicated. Incomplete applications will not be processed until missing information is received.

PATIENT REQUIREMENTS:

- Must be a U.S. citizen or resident, with a valid Social Security Number.
- Patient must have no insurance coverage either private and/or public -or-
- Medicare Part D Applicants: If Part D does not allow or pay for any part of your medication, you will be viewed as having no insurance. Being in the donate hole does **not** qualify.
- Provide a list of other medications you are currently on.
- Must be under the care of a licensed health care provider who is authorized to prescribe, dispense and administer medicine in the U.S.
- Complete and sign the Patient Information Section
- Proof of ANNUAL household income documentation is required with each application.
- Acceptable forms of documentation include:
  - Copy of most recently filed Income Tax Return (IRS Form 1040) or W-2 -or-
  - Copy of transcript received through submission of IRS 4506-T -or-
  - Copy of most recent Social Security/Disability monthly check, award letter, benefit statement of 1099 -or-
  - Copy of Unemployment Determination letter
  - Certified letter stating you have no income in your total household

INCOME ELIGIBILITY CRITERIA REQUIREMENTS:

Total house hold income (adjusted gross/taxable income) must not exceed income criteria listed below (amount may change annually):

Persons in Household	Annual Income
1	$17,621
2	$23,752
3	$29,882
4	$36,013
5	$42,144

For each additional person add $6,131

HEALTHCARE PROVIDER REQUIREMENTS:

- Complete and sign the Healthcare Provider Information section. Fax or call a 90 day supply prescription in to Truax Patient Services at (877) 438-9759 along with refills or by signing Healthcare Provider information, we will take this as a legal prescription.
- Provide Doctor NPI Number.
- Complete the REQUESTED MEDICATION section.

SUBMIT COMPLETED APPLICATIONS BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- MAIL: Truax Patient Services / 602 Beltrami Ave NW STE 105 / Bemidji, MN 56601
- FAX: (877) 438-9759

Medication will be mailed to the patient through Truax Patient Services Pharmacy unless viewed as a health risk to be mailed to patients address. You will be notified upon completion of our review and evaluation. Please note, program rules are subject to change without notice. If you have questions or need further assistance, please call (218-766-7290)(218-766-6593), between 9:00AM and 4:00PM Central Standard Time, Monday through Friday.

Sincerely,
Kowa Pharmaceuticals America, Inc.
Patient Assistance Program

revised 10.16.13

Kowa Pharmaceuticals America, Inc. / KPAssist
Truax patient Services / Individual Patient Assistance Program Application
602 Beltrami Ave NW STE 105 / Bemidji, MN 56601 / Phone: (877) 438-9759 / Fax: (877) 438-9759

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN				
FIRST NAME:	**MI:**	**LAST NAME:**		**BD: / /**
Mailing Address:		City:	State:	Zip:
Social Security #:		Phone #: ( )		
Contact person if different from above:			Phone #: ( )	
Drug Allergies:				
Medications currently on:				

PATIENT ELIGIBLITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)
TOTAL ANNUAL HOUSEHOLD INCOME: $________________ (include all annual income, wages, social security, pension, disability, interest earned on savings, etc.)
Household Size (number of persons living in the home) :
Are you currently enrolled in a Medicare Part D Prescription Drug Plan? YES____ NO____
Do you have any public or private prescription drug coverage or are you in any benefit program that helps pay for your prescription drugs? **YES____ NO_____**

I attest that the above information is complete and accurate. I attest that I have insufficient financial resources to pay for the prescribed therapy. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. By my signature, I authorize the release of the information about me and my medical condition to the Kowa Pharmaceuticals America, Inc. Patient Assistance Program (KPAssist) and/or their agents. I authorize KPAssist and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into KPAssist and administration of KPAssist, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities KPAssist may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. My signature certifies that the medication received from KPAssist will not be resold nor offered for sale, trade or barter and will not be returned for credit. Additionally, I agree that at any time during my enrollment, the KPAssist may request additional documentation to authenticate the statements made on my application. The KPAssist and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient's Signature: ____ Date: ______________________________

HEALTHCARE PROVIDER INFORMATION: TO BE COMPLETED BY TH PRESCRIBING PRACTITIONER		
First Name:	Last Name:	MD DO NP PA
Facility Name:	NPI #:	
Street Address:		
City:	State:	ZIP:
Phone Number:	Fax Number:	

REQUESTED MEDICATION (PLEASE CHOOSE) – WILL BE TAKEN AS A LEGAL PRESCRIPTION IF SIGNED BY PRESCRIBER			
LIVALO (BRAND)	1mg_____ 2mg_____ 4mg_____	SIG:	#_____ /FOR A 90 DAY SUPPLY # OF REFILLS __________

I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the KPAssist and /or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage, including Medacaid, Medicare or other public or private programs. I understand that KPAssist reserves the right to modify or terminate this program at any time. I understand that KPAssist reserves the right to recall or discontinue product at any time without notice.

Healthcare Provider Signature:____ Date:____________________

Truax Patient Services
Individual Patient Assistance Program Application Disclosure Section
602 Beltrami Ave NW Suite 105 / Bemidji MN 56601 / Phone (877) 438-9759 / Fax (877) 438-9759

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION:

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize the use or disclosure of my health information as follows:

Persons/organizations authorized to use or disclose the information: My insurer, pharmacist, physician or other health care provider.

Persons/organizations authorized to receive the information: Kowa Pharmaceuticals America, Inc. (KOWA PAP) (KPAssist), and authorized employees. Truax Patient Services and its authorized employees.

Purpose of requested use or disclosure: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.

This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.

This Authoriaztion may include disclosure of information relating to mental health treatment (except psychotherapy notes) only if I place my initials on the appropriate line below. I specifically authorize the release of such information to the person/organization listed above.

_______________ Mental Health Information
(initial here)

EXPIRATION:

This Authorization expires one (1) year after I cease to participate in the Program.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling (651) 587-0964 and mailing a written revocation, signed by me or on my behalf, to Truax Patient Services 602 Beltrami Ave NW suite 105, Bemidji, MN 56601. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclose in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization.

Patient Signature ______________________________________ Date ____ / ____ / ____