NASCOBAL®
(Cyanocobalamin, USP) Nasal Spray

PLEASE DO NOT FAX THIS PAGE BACK

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

- Application must be completed, signed and dated by both the Healthcare Professional and Patient.
- Patient must submit one of the following pieces of Proof of Income documentation:
  - I. Federal Income Tax (form 1040 or 1040EZ) with appropriate schedule (C and/or F)
  - II. Federal Income Tax Form 1099
  - III. Yearly benefits statement (SSA, 1099, etc.)
  - IV. Award letter
  - V. Bank statements showing automatic deposit for the current calendar year
  - VI. Minimum of 3 most current pay stubs

ELIGIBILITY & REQUIREMENTS

- Patient cannot have prescription coverage through any Private Insurance, State or Federal Program.
- Patient's annual household income must be at or below 200% of the current Federal Poverty Level.

GENERAL PROGRAM INFORMATION

- The requested medication will ship to the Healthcare Professional's office.
- Before the patient is due for a refill, the Healthcare Professional and the Patient must sign and submit a new application.
- For assistance with program enrollment, please contact the NASCOBAL® Patient Assistance Program at:

1 (800) 589-0841

PATIENT CHECKLIST

- Patient or Patient Caregiver provided complete information as requested in STEP 1 and Step 2. YES NO
- Patient or Patient Caregiver has and will supply required proof of income documentation. YES NO

If "NO" to proof of income, please contact NASCOBAL® Patient Assistance Support Line at: **1 (800) 589-0841**

- **If Patient has insurance coverage, please provide a copy of your insurance cards (both sides).**

HEALTHCARE PROFESSIONAL CHECKLIST

- Healthcare Professional provided complete information as requested in STEP 3 and STEP 4. YES NO

endo pharmaceuticals
an endo international company

Rx Only

NS-04229/December 2015 www.nascobal.com 1-800-462-ENDO (3636)

NASCOBAL®
(Cyanocobalamin, USP) Nasal Spray

Patient Assistance Program
1267 Professional Parkway, Gainesville, GA 30507
Phone: (800) 589-0841
Fax: (855) 828-1491

STEP 1 – PATIENT INFORMATION – TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

Patient First Name: MI: Patient Last Name:

Address:

City: State: Zip: Gender: Male Female Marital Status: S M W D

Phone: Date of Birth: (MM/DD/YYYY) Social Security #:

Are you a U.S. Resident? Y N Are you a Veteran? Y N Are you Disabled? Y N

Gross Annual Household Income: Number of Persons in Household:

Contact Name: (if other than patient) Relationship to Patient:

Proof of Income Documentation is required for this program. Please select the documents you intend to submit:

Federal Tax Return Social Security Income Bank Statements/Paycheck Stubs (minimum of 3)

Other:

STEP 2 – PATIENT INSURANCE INFORMATION – TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

What type of insurance coverage do you have? ***NO INSURANCE COVERAGE?*** Circle Here

Medicare Part A Medicare Part D Medicare Advantage

Medicare Part B Employer Other

For each insurance policy you have, please attach a copy of both the front and back of your insurance card and fill in the following:

Primary Insurance Name: Secondary Insurance Name:

Phone Number: Phone Number:

Policy ID: Policy ID:

Group Number: Group Number:

I certify that the information in Sections 1 and 2 are 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, except otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize Endo Pharmaceuticals Inc. to obtain and disclose information from physicians, insurance companies and others as necessary to verify the information provided on this application.

Patient Signature: Date: / /

STEP 3 – PROFESSIONAL INFORMATION – TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR OFFICE

DEA Number: (if applicable) NPI Number: Expiration Date:

State License Number: Expiration Date:

Physician First Name: Physician Last Name: Prof. Designation:

Address:

City: State: Zip: Office Contact:

Telephone: Ext: Fax: Physician Email:

STEP 4 – PRESCRIPTION INFORMATION – THIS IS THE PRESCRIPTION; NO ADDITIONAL PRESCRIPTION IS NEEDED

Product	Dosage	Administration	Distribution	Refills
NASCOBAL® (Cyanocobalamin, USP) Nasal Spray	500 mcg/spray		90-Day Supply	0 1 2 3

I certify that the information in Section 3 is complete and accurate to the best of my knowledge. I understand that additional information may be requested to process this application, but that all information will be kept confidential, except otherwise required by law. I hereby authorize Endo Pharmaceuticals Inc. to obtain and disclose information from insurance companies and others as necessary to verify the information provided on this application.

Healthcare Professional Signature: Date: / /