Reliant PHARMACEUTICALS LLC
Rx Support Program

ENROLLMENT APPLICATION

The Reliant Rx Support Program provides temporary prescription medication to eligible patients who have special needs due to short-term financial hardship. To enroll, please complete this application.

Section I: TO BE COMPLETED BY *PATIENT* OR *LEGAL GUARDIAN*

Patient Name (first):_____ (MI):_____ (last):_____

Social Security #:_____ Date of Birth_____ Phone #_____

Address:_____

City:_____ State_____ Zip Code:_____

_____*Check here if NEW patient application.*

_____*Check here if change of address.*

Is patient a US Citizen or legal resident alien?
YES_____ NO_____

Sex M_____ F_____

Number of people in the household? _____

Please provide the following information in order to assess program eligibility

Gross Household Monthly Income Before Taxes: $_____
(Including all Income, Wages, Social Security Income, Pension, Unemployment, Alimony, Disability, etc.)

Amount of Liquid Assets: $ _____
(savings, checking, IRA, CDs, stocks, bonds)

If $0, please explain_____

	Yes	No	
Income	☐	☐	I am unable to pay for the product(s). **ATTACH COPY OF MOST RECENT FEDERAL TAX RETURN, IF APPLICABLE**
Prescription Plan	☐	☐	I am not covered under a private prescription reimbursement plan or government prescription program through Medicare, Medicaid, VA, military, state or local plans. (A proof of denial letter must be submitted demonstrating that you have applied and have been rejected.) **If qualified for Medicare or Medicaid, you must have already exceeded the prescription drug limit for this calendar year and must provide supporting documentation).** **ATTACH COPY OF PROOF OF DENIAL LETTER**

I authorize Reliant Pharmaceuticals and their consultants, representatives, and agents to use this information to assess my eligibility for participation in the Reliant Rx Support Program, including the audit of my medical records and/or contacting me directly to confirm my eligibility. I understand that this assistance is temporary and that this program and any assistance provided may be discontinued or changed at any time without notice. I certify that I do not have the ability to pay for my medication and that I have no government or private insurance to pay for my medication. I understand that the provision of free medication is a philanthropic activity by Reliant, and therefore, the Reliant Rx Support Program is considered the payer of last resort. I attest that the information I have provided is correct and complete.

_____ _____

Original Signature of Patient or Legal Guardian ***Date***

Section 2: TO BE COMPLETED BY *HEALTHCARE PROFESSIONAL (HCP)*

HCP's (full) Name:_____

Specialty:_____

Mailing Address:_____

_____

City:_____ State:_____ Zip Code:_____

HCP's State License #:_____

Date of Issuance:_____

HCP FAX#: (_____) _____

Contact Name:_____

Telephone #(_____) _____

I certify, to the best of my ability, that the information above is correct and the prescription(s) is/are medically necessary for the above patient. I have received this patient's consent to enroll him/her in the Reliant Rx Support Program, and I agree to allow Reliant, or an authorized representative, to review the medical, financial, and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I understand that no third party or patient should be charged for this medication provided by Reliant. This program is not intended for long-term support. I agree to notify Reliant Rx Support Program of any changes I become aware of that would affect the eligibility status of the patient. My signature certifies that goods received from Reliant for patient assistance is for the uses of the above named patient. These goods will not be offered for sales, trade or barter and will not be returned for credit. Reliant Pharmaceuticals reserves the right to stop the product(s) when necessary.

_____ _____

Original Signature of Healthcare Professional ***Date***

Please complete the product box and include the strength and daily dosing instructions for the product (s) prescribed

☐ First Application for product ☐ Reapplication for product

Product	Strength	Dosage

Please complete the Enrollment Application on the reverse side

AN INCOMPLETE FORM WILL RESULT IN A DELAY IN PROCESSING THIS REQUEST. INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.

Patients must include documentation to support gross monthly household income and a proof of denial letter from any government prescription program and/or Medicare or Medicaid program.

IN ORDER TO EXPEDITE THIS PROCESSING OF THE APPLICATION FOR PATIENT ELIGIBILITY, PLEASE NOTE THE FOLLOWING:

To the Patient:

- ❑ Complete section 1 of this application. (PLEASE PRINT LEGIBLY.)
- ❑ Number of people in household includes EVERYONE living in the home.
- ❑ Attach copy of most recent federal tax return
- ❑ Attach copy of proof of denial letter from a Federal Government Prescription Program

Total Household Monthly Income: Include the total DOLLAR amount for your total GROSS MONTHLY income. Include income from salary/wages/dividends, social security, social security supplemental income, disability, unemployment compensation, pension/annuity, alimony/child support, rental income etc. Please be sure to include gross monthly income for yourself and your dependents.
Remember: You must include a copy of the most recent federal tax return to support your gross monthly household income.

Liquid Assets: Include the total DOLLAR amount. Include the sum of your savings and checking accounts, IRA, CDs, stocks and bonds.

NOTE: A revalidation form must be completed and submitted for all patients after each 90 days (3 months) of program assistance.

To the Healthcare Professional:

- ❑ Complete section 2 of this application. (PLEASE PRINT LEGIBLY.)
- ❑ ORIGINAL SIGNATURES ONLY - no stamp or photocopies.
- ❑ UPS will only deliver to a street address - not to a P.O. box.
- ❑ Attach an original, signed prescription to the application.

NOTE: An updated, original application is needed every time a patient needs a new medication. Photocopies of old applications will not be accepted.

Signature and Date: Both the healthcare professional and patient or legal guardian must sign and date the application attesting that the information provided is both complete and accurate.

Please collect all information needed to complete the application on the reverse side. Please indicate the product, strength, and dosage for the medication you are prescribing for this patient. Once all the information is gathered, including income documentation and proof of denial letter from your patient, **please sign and date** the form. Mail the completed application to the address below. Call 1-866-RxCares (1-866-792-2737) if you have any questions or need assistance. Reliant reserves the right to change the provisions of this program and to change or remove products available through this program.

Reliant R_x Support Program
PO Box 6842

Somerset, NJ 08875-9878
QUESTIONS OR NEED ASSISTANCE
Call 1-866-RxCares
1-866-792-2737