SP-CARES PATIENT ASSISTANCE PROGRAM ENROLLMENT APPLICATION

P.O. Box 52122 • PHOENIX, AZ 85072

BOTH SIDES OF FORM MUST BE COMPLETED

PART ONE - Patient Information

Name:_____

Address:_____City:_____

State:_____ ZIP:_____ Phone #: (_____) _____ - _____

Date of Birth:_____/_____/_____	US Resident: ☐ Yes ☐ No	Marital Status: ☐ Single ☐ Married

Number of persons (including self) DEPENDENT upon the family income:_____

Does the patient have any coverage that pays all or part of their prescription medication? ☐ Yes ☐ No
(Medicaid, Medicare supplemental, other state or local programs or private insurance)

Does the patient qualify for Medicare? ☐ Yes ☐ No

Total Monthly Household Income - Proof of income from all sources must be attached (see reverse side for details).

Salary/Wages	$	Unemployment Compensation	$
Social Security	$	Pension	$
Social Security Supplemental	$	Investment Income	$
Disability	$	**TOTAL**	$

I attest that the information provided in this application is complete and accurate. By my signature, I authorize Schering and its authorized agent(s) to request and to obtain from my healthcare provider, insurance company or other necessary party, any of my medical records and information, financial and insurance records and information, and/or any other information necessary for the purpose of verifying the accuracy of the information provided in this application or related to my enrollment or participation in the Program. I understand that all personal identifying information obtained by Schering Corporation in response to this application, will be used by Schering and its authorized agent(s) to administer the Program and will not be used or disclosed for any other purposes, except as may be required or permitted by applicable law. I also understand that information about all program participants may be summarized for statistical or other purposes, but that my identity cannot be determined from this summary information. I understand that Schering reserves the right at any time and without notice to modify the application form or the eligibility criteria; modify or discontinue any or all aspects of the Program; or terminate any assistance provided by the Program. I understand that my prescribing physician is responsible for choosing which prescription products are right for me. Schering Corporation is not responsible for verifying my medical condition or my prescribing physician's selection of products.

*Patient's Signature:*_____ *Date:*_____

PLEASE CHECK THE PRODUCTS ON THE BACK THAT YOU WANT TO ORDER

PART TWO - Physician Information

Prescriber Name:_____ Prescriber's Title:_____

Facility Name:_____

Shipping Address:_____
(Street Address please, UPS will not deliver to a P.O. Box)

City:_____ State:_____ ZIP:_____

Mailing Address:_____

City:_____ State:_____ ZIP:_____

DEA or State License #:_____ Phone #:_____ Fax #:_____

Name of Office Contact Person:_____ Title:_____

To the best of your knowledge does the patient have prescription drug coverage? ☐ Yes ☐ No

I certify that the information provided in this application is complete and accurate to the best of my knowledge and that the product ordered hereunder is medically indicated for this patient. I further certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party shall be charged for such product. Additionally, no units of product will be submitted for Medicare, Medicaid, or any public or private third party reimbursement, or returned for credit. I understand eligibility under this Program is subject to Schering's approval and the patient's continuing compliance with all eligibility requirements, as set by Schering from time to time. I agree to allow Schering, or its authorized agent(s), to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the Program and the patient's receipt of any product(s) provided to him or her through the Program.

*Prescriber's Signature:*_____ *Date:*_____
(photocopies or stamped signatures will not be accepted)

PART THREE - Product Information - THIS SECTION MUST BE COMPLETED

Patient Name *(please print)*:_____

Please check the requested product needed. Only those products listed are available on the program.
All product will be shipped to the physician's office as a three-month supply with the exception of AVELOX, CIPRO, CIPRO XR, and FORADIL.

ASMANEX® TWISTHALER® 220 mcg (mometasone furoate inhalation powder) ☐ 30 inhalation units ☐ 60 inhalation units ☐ 120 inhalation units

AVELOX® (moxifloxacin) ☐ 400 mg tablet (bottle of 5) ☐ 400 mg tablet (bottle of 30)

BILTRICIDE® (praziquantel) ☐ 600 mg tablet (bottle of 6)

CIPRO® (ciprofloxacin HCl) Tablet ☐ 250 mg tablet (bottle of 100) ☐ 500 mg tablet (bottle of 100) ☐ 750 mg tablet (bottle of 50)

CIPRO® XR (ciprofloxacin HCl) ☐ 500 mg (bottle of 50) ☐ 1000 mg (bottle of 30) ☐ 1000 mg (bottle of 50)

CIPRO® SUSPENSION (ciprofloxacin) ☐ 250 mg ☐ 500 mg

CLARINEX® (desloratadine) ☐ tablets ☐ syrup **CLARINEX® RediTabs®** ☐ 2.5 mg ☐ 5.0 mg

CLARINEX-D® 24-HOUR (desloratadine 5 mg/pseudoephedrine sulfate, USP 240 mg) EXTENDED RELEASE TABLETS ☐ tablets

DIPROLENE® (augmented betamethasone dipropionate)
Lotion: ☐ 30 mL bottle ☐ 60 mL bottle ***Ointment*:*** ☐ 15 g tube ☐ 50 g tube ***AF Cream:*** ☐ 15 g tube ☐ 50 g tube

ELOCON® (mometasone furoate)
Lotion*: ☐ 30 mL bottle ☐ 60 mL bottle ***Ointment:*** ☐ 15 g tube ☐ 45 g tube ***Cream*:*** ☐ 15 g tube ☐ 45 g tube

FORADIL® AEROLIZER® (formoterol fumarate inhalation powder) ☐ 12 mcg

IMDUR®* (isosorbide mononitrate) ☐ 30 mg ☐ 60 mg ☐ 120 mg

K-DUR®* (potassium chloride) ☐ 10 meq ☐ 20 meq

LOTRISONE® (clotrimazole/betamethasone diproprionate) ***Lotion*:*** ☐ 30 mL bottle ***Cream*:*** ☐ 15 g tube ☐ 45 g tube

NASONEX® (mometasone furoate monohydrate) Number of spray bottles requested:_____

NITRO-DUR® (nitroglycerin) ☐ 0.1 mg/HR ☐ 0.2 mg/HR ☐ 0.3 mg/HR ☐ 0.4 mg/HR ☐ 0.6 mg/HR ☐ 0.8 mg/HR

PROVENTIL® (albuterol sulfate)
☐ Aerosol Inhaler* Number of inhalers requested:_____
☐ UD (24 x 3 mL) solution* Number of boxes requested:_____
☐ PROVENTIL HFA Number of inhalers requested:_____

To minimize interruption of therapy, SP-Cares Patient Assistant Program will provide you with either a brand name product or a comparable generic product manufactured and/or distributed by Schering Corporation.

PROOF OF INCOME REQUIREMENTS

Proof of monthly income for all persons in the household must be attached. Acceptable documents are:

- *Monthly pay stub (current within the last two months)*
- *Yearly benefits (Social Security, etc.) can be award letter, benefit statement, or bank statements showing automatic deposit for the current calendar year*
- *Self-employed patients must attach a copy of most current Federal Income Tax form with appropriate schedules (C and/or F)*
- *If you have no income, you must attach a note from your physician or social worker on their letterhead stating to the best of their knowledge you have no income*

Return completed application with proof of income to:

SP-Cares
Patient Assistance Program
P.O. Box 52122 • Phoenix, AZ 85072
or FAX to 1-800-995-9620

A REORDER FORM WILL BE INCLUDED WITH YOUR APPROVAL LETTER.
Call 1-800-656-9485 for questions regarding the program.

Schering Corporation will make every effort to grant aid to a patient in need; however, this program may be discontinued at any time.