P.O. Box 5666
Louisville, Kentucky 40255-0666
Phone: 1-888-CARES-55 (1-888-227-3755)
Fax: 1-877-9-CARES-9 (1-877-922-7379)

Thank you for your interest in the Shire Cares Patient Assistance & Support Program. If you are having trouble affording your Shire medicines, this program is designed for you.

The type of assistance available varies based on the medicine that has been prescribed for you, your household income, and your insurance status. To receive prescription medicine assistance from Shire Cares, you and your doctor must complete and submit this application form in its entirety, and meet program eligibility requirements. We have included a checklist at the bottom of this page to guide you through completing and submitting your application.

If you have any questions, please call the program at 1-888-CARES-55 (1-888-227-3755). We are available to answer your calls Monday through Friday, from 8 AM to 8 PM Eastern Time, except for Holidays.

Please note: Submission of a complete application form does not guarantee enrollment in Shire Cares. Each application will be considered on a case-by-case basis. For your convenience, the general income guidelines for free assistance with your Shire medicines are included below.

Number of People in Your Household	Maximum Total Yearly Income
1 person	$35,310
2 people	$47,790
3 people	$60,270
4 people	$72,750
5 people	$85,230

Please check one:
☐ New Application
☐ Renewal Application

APPLICATION CHECKLIST: *Please ensure all items on the list are completed and attached, or the application may be delayed*

- ☐ Complete all fields in Section 1
- ☐ Fill out prescription information in Section 2
- ☐ Indicate medicine shipping preference in Section 2
- ☐ Sign and date the application form (no stamps; only original signatures accepted)
- ☐ Fill out your personal information in Section 3
- ☐ Fill out your financial information in Section 4
- ☐ Attach proof(s) of income for your household
- ☐ If you have health insurance: fill out your insurance information in Section 5 and attach a copy of your insurance card
- ☐ Sign and date the application form

Please keep a copy of the application for your records

When you and your doctor have completed both checklists above, send your form to us by fax or mail. Incomplete or incorrect information may delay the processing of your application, so please ensure that all information is provided correctly and that all signatures are obtained.

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PHYSICIAN COMPLETES THIS PAGE

SECTION 1: *TREATING & REFERRING (if applicable) PROVIDER INFORMATION*

Treating Physician Name _____ *DEA# _____

National Provider ID _____

Facility Name _____ Tax ID _____

Address (No PO Box) _____

City _____ State _____ Zip _____

Phone _____ Ext _____ Secure Fax _____

Clinic Contact _____ Contact Title _____

Referring Physician Name _____ *DEA # _____

National Provider ID _____

Facility Name _____ Tax ID _____

Address (No PO Box) _____

City _____ State _____ Zip _____

Phone _____ Ext _____ Secure Fax _____

Clinic Contact _____ Contact Title _____

***DEA Identification number required only if prescribing a controlled substance**

SECTION 2: *THIS IS THE PRESCRIPTION; NO ADDITIONAL PRESCRIPTION IS NEEDED (TO BE COMPLETED BY DOCTOR ONLY)*

Patient Name _____ **Patient Date of Birth** _____

Diagnosis _____

Product *(please select)*	**Dosage**	**Administration**	**Distribution**
☐ Vyvanse® (lisdexamfetamine dimesylate) Capsules CII	Prescription given to patient for use at pharmacy		☑ Pharmacy Card

Please Note: Coverage will not exceed the maximum daily dosage as indicated within Vyvanse prescribing information. Approval for up to 12 months.

Product *(please select)*	**Dosage**	**Administration**	**Distribution**	**Refills** (please select)
☐ Carbatrol® (carbamazepine) Extended-Release Capsules	☐ _____ mg		☑ 90-day supply	❍1 ❍2 ❍3
☐ FOSRENOL® (lanthanum carbonate) Chewable Tablets	☐ _____ mg		☑ 90-day supply	❍1 ❍2 ❍3
☐ FOSRENOL®(lanthanum carbonate) Oral Powder	☐ _____ mg		☑ 90-day supply	❍1 ❍2 ❍3
☐ Lialda® (mesalamine) Delayed-Release Tablets	☐ _____ mg		☑ 90-day supply	❍1 ❍2 ❍3
☐ PENTASA® (mesalamine) Controlled-Release Capsules	☐ _____ mg		☑ 90-day supply	❍1 ❍2 ❍3
☐ INTUNIV® (guanfacine) Extended-Release Tablets	☐ _____ mg		☑ 90-day supply	❍1 ❍2 ❍3

Ship Product to: ☐ Physician's Office ☐ Patient's Address *(If no selection is made, product will be shipped to Patient's Address)*

Physician / Prescriber Attestation

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

Original Signature of Licensed Practitioner (no stamps accepted) _____ Date_____

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PATIENT COMPLETES THIS PAGE

SECTION 3: *PATIENT PERSONAL INFORMATION*

Patient Name _____ Date of Birth _____

Phone _____ Gender ☐ Male ☐ Female

Social Security Number _____ US Citizen / Legal Resident? ☐ Yes ☐ No

Address (No PO Box) _____

City _____ State _____ Zip _____

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

May we share patient protected health information with your designated contact person? Yes☐ No ☐

SECTION 4: *PATIENT FINANCIAL INFORMATION*

Number of people in your household Adults = _____ **Children =** _____

Total combined income for you, your spouse, and your dependents $ _____ Annually

You must provide proof of income to apply for this program. Please provide a copy of your most recent:

☐ Federal Tax Return **or** ☐ Pay Stubs (full month's worth of recent pay stubs) **or** ☐ Social Security Awards Letter

Have you lost your job in the past three (3) months? ☐ Yes ☐ No → If Yes, please attach proof of job termination or unemployment.

SECTION 5: *PATIENT INSURANCE INFORMATION*

Is your copay over $50 and/or your deductible over $1,000? ☐ No → If Yes, please provide proof showing your copay and/or deductible on your insurance company's letterhead.

What type of insurance coverage do you have? (Check all that apply)

☐ None

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid

☐ State Pharmacy ☐ Employer ☐ Other _____ (Please fill in Name of Insurer)

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

Primary Insurance		Secondary Insurance	
Insurance Plan		Insurance Plan	
Phone Number		Phone Number	
Name of Policy Holder		Name of Policy Holder	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Policy ID		Policy ID	
Group Number		Group Number	
Plan Type		Plan Type	

Has your insurance plan denied coverage for this medicine? ☐ Yes ☐ No → If Yes, proof of the denial is required. Please provide with this application.

****If the medicine is not covered by your plan, please provide a patient-specific letter from the insurance company stating no coverage.**

Are you a Veteran? ☐ Yes ☐ No → If Yes, have you applied for VA benefits? ☐ Yes ☐ No

SECTION 6: *PATIENT AUTHORIZATION*

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other health care provider to disclose to Shire Pharmaceuticals LLC and its agents all medical records and information, financial and insurance records and information as well as other identifying information, for the purpose of my participation in the Shire Cares Patient Assistance Program or for the purposes of gathering information on side effects or other safety issues reported to Shire in order to determine if such safety issues are related to the Shire medicine I am taking. I also authorize Shire Pharmaceuticals LLC and its agents to contact my hospital, physician or other health care provider to obtain follow-up information on any such side effects or safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC and its agents to disclose all such records and information to any 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 no prescription coverage for the prescribed medicine, including all public programs, and have insufficient financial resources to pay for the prescribed medicine. I understand that Shire Pharmaceuticals LLC reserves the right at any time and without notice to modify the application or modify or discontinue this program and related eligibility criteria. I authorize Shire Pharmaceuticals LLC to use my Social Security Number for identification purposes and record keeping only.

Patient Name (Print) _____

Patient Signature _____ Date _____

→ If patient cannot sign or is <18 years of age, patient's representative must sign below

Patient Representative Name & Relationship to Patient (including description of authority to make medical decisions for patient)

_____

Patient Representative Signature _____ Date _____