Sun Pharma Imatinib Patient Services Program
Application *for* Patient Assistance Program

What is Patient Assistance?

- The Sun Pharma Imatinib Patient Assistance Program is offered to allow qualified patients to obtain free medication. It is not a government program or an insurance plan.
- If a patient qualifies, they may receive free Imatinib medication each month through July 2016 as long as they continue to meet the program requirements.
- Medication will be sent directly to the patient's home or an alternate shipping address of choice. All packages require a signature at the time of delivery.
- Medication is sent in a 30 day supply.

Program Qualification:

Patient may qualify for the Program if:

- The patient does not have existing drug coverage for the prescribed product under any prescription drug benefit, including private insurance, Medicare, Medicaid, or other government insurance programs ***or*** the Patient is in the 90-Day Waiting Period for Medicare coverage.
  and
- The patient is a U.S. Resident, Green Card or Work Visa holder.
  and
- The patient has an income at or below 500% of the Federal Poverty Level (FPL)

  or the patient has experienced a recent financial challenge due to circumstances such as changes in household income, loss of employment, changes in marital status or changes in household number: *(Supporting documentation explaining changes in circumstance and new income will be required).*

Sun Pharma reserves the right to change, rescind, or revoke this program at any time.

If you think you, the patient, or as the caregiver your patient qualifies for the Program please complete and sign the application on the next page and fax to 866-810-3258.

Next Steps

QUESTIONS: Call: 844-502-5950; FAX the following documents to 866-810-3258
If patient has no insurance:

- Completed application
- Proof of income: *(include **one** of the following)*
  - ☐ A copy of last year's federal income tax returns for patient, spouse, and dependents
  - ☐ All income statements from jobs (W2 or 1099)
  - ☐ Social Security Income Yearly Benefits Statement

If patient has financial hardship:

- Supporting documentation explaining changes in circumstances (i.e., loss of employment, change in marital status, etc.) will be required along with income information.

Sun Pharma Imatinib Patient Services Program

*Please print clearly in **black** or **blue ink.** Once you have completed this page, please fax to 866-810-3258.*

Patient Information

Name: _____ Date of Birth: ___/___ /___ (mm/dd/yyyy)
First Middle Initial Last

Address: _____ City: _____ State:_____ Zip: _____

Phone: (_____) _____ Gender: ☐ Male ☐ Female

Social Security Number

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If you don't have a Social Security Number you must provide one of the following:

- ☐ Green Card Number:_____
- ☐ Confirmation letter from the government stating a U.S. Green Card application has been submitted
- ☐ Work Visa Number:_____

Income

Number of people in household: _____
(include patient, spouse and dependents)

Total combined household income: $_____Monthly **or** $_____Yearly
(include patient, spouse and dependents)

***NOTE:** Patient will need to provide proof of income*

Insurance

Does the patient have any form of prescription drug coverage?

- ☐ Employer furnished or private drug coverage
- ☐ Medicaid
- ☐ Medicare Part A
- ☐ Medicare Part B
- ☐ Medicare Part D
- ☐ VA or Military Benefits
- ☐ State assistance program for medicine
- ☐ None

PATIENT ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

The Sun Pharma Imatinib patient assistance program (PAP) must have the patient's authorization to determine eligibility for patient assistance and to conduct insurance research. By signing below, I authorize Sun Pharmaceutical Industries, Inc.("Sun Pharma") and/or its affiliates, and Diplomat Pharmacy, Inc. and/or its affiliates ("Diplomat") to contact me, my insurer(s), and physicians, and authorizes my insurer(s) to disclose to Diplomat my Protected Health Information, as defined within 45 C.F.R. § 160.103, including but not limited to medical records and treatment, health insurance coverage, my name, address, telephone number, insurance plan, and/or group numbers. Furthermore, I authorize Diplomat to provide the insurer(s), including Medicare, with my name, date of birth, Social Security Number, diagnosis, insurance information or other relevant information about me. By signing below, I also attest that the financial information I have provided is complete and accurate and agree that Diplomat may verify this information. I understand that my choice about whether to sign this Attestation and Authorization for Release will not change the way my healthcare providers or insurer(s) treat me. I understand that I may cancel (revoke) this Authorization for Release at any time by contacting Diplomat or Sun Pharma. I understand that once my Protected Health Information is disclosed, it will no longer be protected by federal privacy law as Protected Health Information and may be re-disclosed. I acknowledge that Sun Pharma reserves the right to change or revoke this program at any time. By signing below I authorize Diplomat to contact me directly about available assistance programs, treatments and therapies and/or reimbursement and access related information.

Patient Signature: _____ **Date**: _____
(If patient cannot sign, patient's legally authorized representative must sign)

Sun Pharma Imatinib Patient Services Program

Prescriber Information

Prescriber's Name:_____Phone: (_____) _____

NPI #: _____Fax: (_____) _____

Address:_____

City:_____ State:_____ Zip:_____

Prescription	
Patient Name:	**DOB:**
Product	
Imatinib _____mg Qty: 30- Day Supply Sig: Refills:	
Product(s) to be filled for a 30 day supply with refills authorized for up to one year from original date of this prescription. Product(s) will be shipped direct to the patient.	
Print Prescriber Name: _____ **Prescriber Signature:** _____ **Date:** _____	

Next Steps

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