PREZISTA™ (darunavir 300 mg) tablets
PATIENT ASSISTANCE PROGRAM
ELIGIBILITY APPLICATION FORM
Telephone 866-836-0114

Online SUBMISSION and Copies of this form are Available at www Tibotec TherapeuticsLine.com

Mail or fax this completed form to:
TibotecTherapeuticsLine, P.O. Box 1016, San Bruno, CA 94066
Fax 1-800-836-0567

Patient Information (Please Print Clearly)

New Application Yes __ No __ | Renewal Yes ___ No ___

Name of Patient M_____ F____

_____

Name of Guardian (if appropriate)

_____

Patient's Address City State Zip

_____

Phone Number – Home Phone Number – Work

_____

Date of Birth Social Security Number

_____

Does this patient have insurance coverage for PREZISTA™ (darunavir 300 mg) tablets? _____ Yes _____ No

Has patient applied to public programs such as ADAP or other drug assistance program? _____ Yes _____ No

If Yes, date applied _____

If yes, to which programs? _____

_____

Financial Qualification for Program

I have _____estimated net assets.

Gross Annual Household Income and Source of Income

Salary/Wages/Unemployment	$_____
Pension/Social Security	$_____
SSI	$_____
SSDI	$_____
Other _____	$_____
	$_____
Total	$_____

I have $0 income. _____ (check if applicable)

Number of household members dependent on income stated above (include applicant) _____

Proof of Income Documentation

Attached is a copy of my most recent federal tax return. (X)	
I do not file federal taxes. (X)	

Applicant Declaration. "I promise that the information on this form is correct and complete. If needed, Tibotec Therapeutics and its Patient Assistance Program (the "Program") may request and obtain information about my, or my family's income to enroll me in the Program. I understand that the Program administrators reserve the right any time and without notice to modify the application form; modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time."

Please indicate your agreement with these terms by signing below.

_____Date_____

Patient Signature or Authorized Representative

If Representative, please explain relationship_____

Provider Information (Please Print Clearly)

Name of Physician

_____

Practice or Facility Name

_____

Address

Line 1_____

Line 2_____

City State Zip

_____

Office Phone Number _____

Office Fax Number _____

Office Contact Name _____

Office Contact Telephone _____

Prescription Information

Name of Drug PREZISTA™ (darunavir 300 mg) tablets

_____

Dose Sig Quantity

"Is the patient currently taking PREZISTA™ (darunavir 300 mg) tablets ?"_____ Yes _____ No

Expected Duration of Therapy (months) _____

Physician Signature

_____

Physician State License Number _____

Direct Shipment Instructions

Please provide special shipping instructions for product shipped directly to physician office or hospital facility (i.e. office hours available for delivery)

_____

_____

_____

Physician Declaration

To the best of my knowledge, this patient does not have prescription drug coverage (including Medicaid, county funded assistance, or other public programs) for PREZISTA™ (darunavir 300 mg) tablets . The PREZISTA™ (darunavir 300 mg) tablets. Patient Assistance Program requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product or administration of product provided under the program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

_____

Physician Signature Date

Authorization to Share Health Information for Reimbursement or Patient Assistance Programs

Provider Instructions: Patients must complete this form before they can participate in the Program.

I, _____, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for PREZISTA™ (darunavir 300 mg) tablets to Lash Group. Lash Group runs the Reimbursement and Patient Assistance Programs (the "Programs") for Tibotec Therapeutics, a Division of Ortho Biotech Products, L.P.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

Lash Group and Tibotec Therapeutics will use and give out this information to see if I qualify for the Programs and to run the Programs. People who work for and with Lash Group and Tibotec Therapeutics may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Programs. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Tibotec Therapeutics, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Tibotec Therapeutics.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Programs.

Patient Sign Here: _____ Date: _____

Patient Name: _____

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: _____

By: _____
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:
_____

A copy of this form must be provided to the patient.