Onset Dermatologics
Patient Assistance Program
P.O. Box 42886 • Cincinnati, OH 45242
Phone: 1-800-956-0697
Fax: 1-513-618-0059

Healthcare Providers can apply online at www.RxHope.com

APPLICATION INSTRUCTIONS

Attn: _____ **From:** _____

Fax: _____ **Date:** _____

Phone: _____ **Number of Pages:** _____

Re: _____ **Patient:** _____

ELIGIBILITY & REQUIREMENTS

- Patient can not have prescription coverage through any private, state or federal program
- Patient's household income must be at or below 200% of the Federal Poverty Level
- Application must be completed and signed by the Health Care Provider and Patient
- Patient must submit annual household Proof of Income
- Medication will be shipped to the Health Care Provider for dispensing

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PRESCRIBER INFORMATION

DEA Number _____ State License Number _____ Exp _____

Prescriber Name _____ Specialty _____

Address _____

City _____ State _____ Zip Code _____ Office Contact _____

Phone _____ Fax _____ Email _____

I verify that the information provided is complete and accurate to the best of my knowledge. My patient referenced above gave consent for me to provide this information. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and shall not be sold, traded or distributed for sale. I shall not seek reimbursement for this medication from any third party.

Prescriber Signature _____ Date _____

PRESCRIPTION INFORMATION

Tretin•X® Cream (tretinoin)
(35mg tube)

☐ 0.0375%

☐ 0.075%

Minocin® Capsules (minocycline)

☐ 50mg

☐ 100mg

Dosage _____

Clindagel® (clindamycin phosphate gel 1%)

☐ 1.0%

Locoid® Lotion 0.1% (hydrocortisone butyrate 0.1%)

☐ 2oz bottle

☐ 4oz bottle

Hylatopic Plus® Foam

☐ 150gm

Hylatopic Plus® Cream

☐ 450gm

Aurstat® Anti-Itch Kit

☐ 100gm/225ml

Aurstat® Anti-Itch Hydrogel

☐ 225ml

PATIENT INFORMATION

Patient First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Phone _____ Date of Birth (MM/DD/YYYY) _____ Gender: ☐ Male ☐ Female

Social Security or Visa # _____ Are you a U.S. resident? ☐ Y ☐ N Are you a Veteran? ☐ Y ☐ N

Number of persons in household _____ Gross Annual Household Income* $ _____

Do you have any prescription coverage for the medication prescribed? ☐ Yes ☐ No _____
If yes, please specify

Are you enrolled Medicare Part D? ☐ Yes ☐ No *Attach a copy of your most recent household income verification.
(U.S. Tax Return, IRS From 1040, Social Security/Disability Statement or monthly check, W-2 forms, or pay stubs are accepted)

I certify that the information provided on this form is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I will not seek reimbursement from any insurance company or government health program for any medication dispensed to me as part of this program, nor will I sell, trade, or distribute any medication given to me by the program. I hereby authorize the program to obtain, disclose, and shre information about my medical condition, treatment, and health insurance coverage between my physicians, insurance companies, and others as necessary to verify the information provided in this application and my eligibility for the program. If my income or health coverage changes, I will notify the program by calling 1-800-956-0697. I know that if I do not sign this form or revoke my authorization, I will not be able to receive assistance from or participate in the program, but this will not affect my ability to get medical care, seek payment for this care or affect my enrollment or eligibility for insurance. I may receive a copy of this form or revoke it at any time by contacting the program at 1-800-956-0697. I understand that this authorization will expire one (1) year after the date it is signed below or one (1) year after the last date I receive medicine from the program, whichever is later.

Patient Signature _____ Date _____

Fax completed application to 1-513-618-0059