Patient Assistance Program

This program is designed to assist physicians and other healthcare professionals that care for patients who are financially disadvantaged and have no source of prescription drug coverage through private insurance or from public assistance (i.e.: Medicaid, Medicare or charitable organizations). In order to be considered under this assistance program the patient must have an annual household income of less than $19,600 for one person or a combined family income of no more than $26,400.

A PRESCRIPTION IS REQUIRED FOR EACH REQUEST. A completed prescription must be attached with an original signature of the prescribing physician. This completed form and the prescription must be returned by mail or fax (585.338.8577) to fulfill the request. Please mail to:

Bausch & Lomb Incorporated
US Patient Assistance Program
1400 N. Goodman Street
Rochester, N.Y. 14609

Thank you again for your interest in Bausch & Lomb's pharmaceutical products. If you have any further questions, please call our Customer Service Department at 800-323-0000.

Practitioner Name:		**State License # :**	
		Expiration Date:	
Address:			
City:	**State:**	**Zip:**	**Phone #**
Ship to the Attention of:			**Fax #**

To the best of my knowledge based upon the information provided to me, this patient either has no public or private prescription insurance coverage for the requested medication or is a Medicare Part D enrollee who is currently in the coverage gap (doughnut hole), or has insufficient financial resources (based upon the guidelines provided above) to pay for the prescribed therapy.

My signature below certifies the following:

1. That the medications I receive from Bausch & Lomb are solely for the use by the patient identified below.
2. That no attempt will be made to apply for reimbursement for any of the products provided from any public or private third party payor on behalf of a qualifying patient under this program.
3. The products provided will not be resold nor offered for sale, sample, trade, barter or used for any other purpose.
4. That the state license information and expiration date provided above is accurate and authorizes me to receive the samples.
5. That the completed prescription provided with this request was completed and signed by me.

Practitioner Signature:	
(Signature of Prescribing Practitioner above) Original signature only – stamps ARE NOT acceptable.	**Date:**

Patient Name:	**Social Security # :**
	Birth Date:

I verify that the information provided in this request is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for the requested medication or am unable to utilize such coverage. I understand I am expected to seek any available state or government assistance before applying to the Bausch & Lomb Patient Assistance Program. No attempt will be made to apply for reimbursement for any of the products provided through Bausch & Lomb's Patient Assistance program from any public or private third party payor. I understand that Bausch & Lomb reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I authorize the use of this information on this application to process my request and authorize the use of my social security number only for identification purposes and record keeping.

Patient Signature:	
Original signature only – copies ARE NOT acceptable.	**Date:**

Below is listed the medication available on the Indigent Patient Program. A maximum of one (1) bottle of any product on any one request. Any request above the specified limit will not be shipped. No substitutions allowed. Please allow 4 – 6 weeks for delivery. Please check appropriate medication below:

	Alrex® (loteprednol etabonate ophthalmic suspension 0.2%) 10 mL	**Qty (max 1):**
	Lotemax® (loteprednol etabonate ophthalmic suspension 0.5%) 15mL	**Qty (max 1):**
	Zylet® (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension) 10mL	**Qty (max 1):**
	OptiPranolol® (metipranolol ophthalmic solution 0.3%) 10 mL	**Qty (max 1):**

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