Boehringer Ingelheim

CARES FOUNDATION

Aptivus® (tipranavir) Viramune® (nevirapine)

Mail to: Boehringer Ingelheim Cares Foundation, Inc.
P.O. Box 42886
Cincinnati, OH 45242
Questions? Call 1-800-319-4033
Fax: 1-513-618-0055

Patient Assistance Program

Section 1 - Physician and Prescription Information			
Physician Name	DEA/State License #:	Phone: Alt. Phone: ( ) Fax:	
Address: (no P.O. Box)	City:	State:	Zip:
Diagnosis (ICD9 Code):			
Prescription			
Drug Name & Strength:	Quantity:		

Physician/Prescriber Attestation: To the best of my knowledge, this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party

Physician Signature:	Date:

Section 2 - Patient Information			
Patient Name:		SS#:	
Street Address:		Date of Birth:	Male ☐ Female ☐
City	State	Zip	Phone
Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 other	U.S. Citizen? Yes ☐ No ☐	Are you a Veteran of the US Armed Forces? Yes ☐ No ☐	Are you Disabled? Yes ☐ No ☐
Did you file a U.S. State and/or Federal Income Tax return last year? Yes ☐ No ☐ If no, why not?			

Financial Information **Note:** You must attach copy of your most recent Federal Income Tax Return, i.e.,IRS Form 1040, 1040A, 1040EZ, 1040NR

List All Sources, Gross Monthly Amounts

Salary/Wages $_____ Social Security $_____ Child Support/Alimony $_____

Social Security Disability $_____ Pension/ Retirement $_____ Unemployment/ Work Comp $_____

Total Gross Household Monthly Income: $_____

Insurance Information	**Check one**	**Policy Number**	**Phone Number**
Private Drug Coverage	☐Yes ☐No		
Medicaid	☐Yes ☐No		
Medicare	☐Yes ☐No		
Medicare Part D	☐Yes ☐No		
State Elderly Drug Assistance	☐Yes ☐No		
Aids Drug Assistance Program	☐Yes ☐No		

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this Application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program.

I hereby authorize the program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application. Boehringer Ingelheim Cares Foundation, Inc. is not responsible for verifying any of the information contained in Section 1 above or other medications that I am taking.

Patient's Signature:	Date: