JDS PATIENT CARE PROGRAM

JDS PHARMACEUTICALS LLC

1 Patient Information: Please complete all required information

Patient First Name _____ Last Name _____

Patient Address _____

City _____ State _____ Zip _____ Phone _____

Date of Birth ___/___/___ US Citizen or Legal Resident Alien ☐ Yes ☐ No Sex ☐ Male ☐ Female

Number of persons (including self) DEPENDENT upon the family income _____

Last 4 digits of Social Security # ☐☐☐☐

Does the patient have any coverage that pays all or part of their prescription medication? ☐ YES ☐ No
(Medicare, VA, other state or local programs or private insurance)

TOTAL MONTHLY HOUSEHOLD INCOME:
Proof of income from all sources must be attached (see reverse side for details).

Salary/Wages	$_____	Unemployment Compensation	$_____
Social Security	$_____	Pension	$_____
Disability	$_____		
		Total	$_____

I attest that the information provided in this application is complete and accurate. I understand that all personal identifying information obtained by JDS Pharmaceuticals in response to this application, will be used by JDS and its authorized agent(s) to administer the Program and will not be used or disclosed for any other purposes, except as may be required or permitted by applicable law. I also understand that information about all program participants may be summarized for statistical or other purposes, but that my identity cannot be determined from this summary information. I understand that JDS reserves the right at any time and without notice to modify the application form or the eligibility criteria, modify or discontinue any or all aspects of the Program or terminate any assistance provided by the Program. I understand that my prescribing physician is responsible for choosing which prescription products are right for me. JDS Pharmaceuticals is not responsible for verifying my medical condition or my prescribing physician's selection of products.

Patient's Signature _____ Date _____

2 Physician Information: Please complete all required information

Prescriber First Name _____ Last Name _____ Title _____

Prescriber Address _____

City _____ State _____ Zip _____

Phone _____ Fax # _____

To the best of your knowledge does the patient have prescription drug coverage ☐ Yes ☐ No

Please check the product(s) requested for this patient: ☐ Pexeva ☐ Lithobid

Note that the monthly maximum quantity limits for this program are: 60 tablets for Pexeva 10, 20, and 30 mg; 30 tablets for Pexeva 40 mg and 120 tablets for Lithobid 300 mg.

I certify that the information provided in this application is complete and accurate to the best of my knowledge and that the product requested hereunder is medically indicated for this patient. I understand that eligibility under this Program is subject to JDS's approval and the patient's continuing compliance with all eligibility requirements, as set by JDS from time to time.

Prescriber's Signature _____ Date _____
(photocopies or stamped signatures will not be accepted)

P.O. Box 2106, Morrisville, PA 19067-0606

3 Eligibility Criteria:

Patients must meet all of the following guidelines to qualify for the JDS Patient Care Program:

- Be a United States citizen or legal resident alien.
- Have no prescription drug benefits through any insurer/payer/program including Medicare, VA, other state/local program or private insurer.
- Have gross monthly household income at or below:

SIZE OF FAMILY UNIT	48 CONTIGUOUS STATES, DC	ALASKA	HAWAII
1	$14,700	$18,375	$16,905
2	$19,800	$24,750	$22,770
3	$24,900	$31,125	$28,635
4	$30,000	$37,500	$34,500
5	$35,100	$43,875	$40,365
6	$40,200	$50,250	$46,230
7	$45,300	$56,625	$52,095
8	$50,400	$63,000	$57,960
For each additional family member, add:	$4,250	$5,313	$4,888

- Proof of income will be required. Examples are outlined below.

4 Proof of Income:

Proof of monthly income for all persons in the household must be attached. Acceptable documents include:

(a) Monthly pay stub (current within the last two months)

(b) Monthly benefits (Social Security, etc) can be award letter, benefit statement, or bank statements showing automatic deposit for the current calendar year

(c) Self-employed patients must attach a copy of most current Federal Income Tax form with appropriate schedules (C and/or F)

(d) If you have no income, you must attach a note from your physician, or social worker on their letterhead stating to the best of their knowledge you have no income.

5 RETURN Completed Application with proof of income to:

JDS Patient Care Program
P.O. Box 2106
Morrisville, PA 19067-0606

Or Fax to:
1-800-233-9141

If you have questions, please call the JDS Patient Care Program at 1-888-296-1826. A customer service representative is available between the hours of 8:30 a.m. and 5:30 p.m. EST Monday through Friday, excluding holidays.