KOS Cares™ Patient Assistance

Pioneering Medicines for a Better Life®

Kos Pharmaceuticals, Inc.
2200 N. Commerce Parkway, Suite 300
Weston, Florida 33326
Toll free: 1- (866) 363-1024
Fax: (954) 331-3778 or (954) 331-3489
Email: KosCares@Kospharm.com

Facsimile Transmittal Sheet

Your office has requested the attached Enrollment information.

Instructions:

NEW APPLICATIONS:
YOU must mail ALL NEW Applications, please **DO NOT FAX**.

Kos Cares Patient Assistance
Kos Pharmaceuticals, Inc.
2200 N. Commerce Parkway, Suite 300
Weston, FL 33326

REFILLS:
YOU may fax or mail the refill prescription.

Fax (954) 331-3778 or (954) 331-3489

MISSING INFORMATION:
To avoid delay, you may identify the Missing Information as "M.I." at the top of each document and mail or fax.

INCOMPLETE APPLICATIONS:
An Application that is considered incomplete will be returned to you. If incomplete, all or some of the following documentation is missing: Proof of income, signatures, Authorization to Disclose form, or the prescription. For your convenience, you may resubmit all the required documentation in the postage-paid return envelope.

Please be sure to review the program's eligibility and financial requirements with your patient.

Thank you for your cooperation.

Total number of pages including cover: 5

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Dear Healthcare Practitioner:

It is our pleasure to provide you with the enclosed 2006 *Kos Cares* patient assistance enrollment application and instructions. ***Pioneering Medicines for a Better Life®*** means caring assistance to patients who meet the following eligibility requirements*:

- Annual income at or below 200% federal poverty guidelines
- The patient must not receive Medicaid or state-sponsored prescription drug assistance
- The patient must not receive private, employee, military, retirement, or pension prescription drug benefits
- You, the Healthcare Practitioner, have determined that a Kos medication is appropriate for treating the patient

Do we have your email address on file? Please complete Section 1 of the Application. Don't miss the opportunity to receive valuable updates about Medicare Part D and other patient assistance related topics.

Please be sure to keep a copy of the enclosed enrollment information for your files. Furthermore, you may view and download enrollment information by clicking on "Contacts" and then "Medical Affairs" at www.kospharm.com.

If you have a question about the status of your patient's application, caring assistance begins with a call to our toll free number **1-(866) 363-1024**.

Sincerely,
Kos Cares Patient Assistance

*Eligibility requirements may change without notice. 3/2006

KOS Cares™
Pioneering Medicines for a Better Life® Patient Assistance

Enrollment Instructions

Pioneering Medicines for a Better Life® means caring assistance, providing free medication to patients who meet the following eligibility requirements:

Please be sure to review the program's eligibility and financial requirements with your patient.

Eligibility Requirements*

- Annual income at or below 200% federal poverty guidelines
- The patient must not receive Medicaid or state-sponsored prescription drug assistance
- The patient must not receive private, employee, military, retirement, or pension prescription drug benefits

Note: If the patient meets the eligibility requirements listed, please be sure to check the eligibility box in **Section 2** of the **Application.**

***Eligibility requirements may change without notice.**

Enrollment Requirements for Prescribing Healthcare Practitioners

To enroll a patient in *Kos Cares:*

- Indicate if **New Application** or if **Refill**
- Complete and sign the prescribing healthcare practitioner's information **Section 1** of the **Application**
- Attach to the Application, a signed prescription by the prescribing healthcare practitioner with the following information:
  - Product Brand Name(s)
  - State Medical License Number and Expiration Date
  - Dosage
  - Quantity (up to 90-day supply)
  - Date
  - Complete shipping address *(no Post Office Box)*

NEW APPLICATIONS:
You must mail ALL NEW Applications, please **DO NOT FAX.**

REFILLS:
You may fax or mail the refill prescription.

MISSING INFORMATION:
To avoid delay, you may identify the Missing Information as "M.I." at the top of each document and **fax to (954) 331-3778.**

INCOMPLETE APPLICATIONS:
An Application that is considered incomplete will be returned to you. If incomplete, all or some of the following documentation is missing: Proof of income, signatures, Authorization to Disclose form, or the prescription. For your convenience, you may resubmit all the required documentation in the postage-paid return envelope provided.

Enrollment Requirements for Patients

To enroll a patient in *Kos Cares,* the patient must:
- Sign the **Application**
- Provide the total number of household members (including self) and the total yearly household income
- Complete and sign the **Authorization to Disclose Information** form

The patient must attach copies of acceptable proof of income:
1. Federal Income Tax Return (Form 1040, 1040A, or 1040EZ) for the prior tax year, **AND**
2. All other current documents that provide proof of income paid to the patient (or the patient's spouse) such as:
   - Wage and Tax Statements (W-2 forms)
   - Social Security, Pension, or Railroad Retirement Statements (SSA-1099)

If the patient cannot provide any proof of income, please call us at toll free **1-(866) 363-1024** for more instructions.

Other Important Enrollment Information

- If the request is approved, a 90-day supply of the requested medication will be shipped to the healthcare practitioner's office. Shipment of medication may take up to eight (8) weeks after receipt of the application. Please be sure to talk with your healthcare practitioner about what to do until your medication is delivered.
- For refills after the initial supply of medication (90 days), a new prescription must be submitted.

Questions? Call us toll free: 1-(866) 363-1024

FAX: (954) 331-3778 or (954) 331-3489

MAIL: *Kos Cares* Patient Assistance
Kos Pharmaceuticals
2200 N. Commerce Parkway, Suite 300
Weston, FL 33326

E-MAIL: KosCares@Kospharm.com

WEBSITE: www.kospharm.com
(Click on **"Contacts"** then **"Medical Affairs"**)

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PAP #

Enrollment Application

Questions? Call toll free: 1-(866) 363-1024 Fax: (954) 331-3778 or (954) 331-3489
Mail: 2200 N. Commerce Parkway, Suite 300, Weston, FL 33326 Email: KosCares@Kospharm.com

SECTION 1: TO BE COMPLETED AND SIGNED BY THE PRESCRIBING HEALTHCARE PRACTITIONER

REQUESTED MEDICATION — PLEASE CHECK PRODUCT(S):
- ❍ Advicor® *(niacin extended-release and lovastatin tablets)*
- ❍ Azmacort® *(triamcinolone acetonide)* Inhalation Aerosol
- ❍ Cardizem® LA *(diltiazem hydrochloride)* Extended-Release Tablets

REQUESTED MEDICATION — PLEASE CHECK PRODUCT(S):
- ❍ Niaspan® *(niacin extended-release tablets)*
- ❍ Teveten® *(eprosartan mesylate tablets)*
- ❍ Teveten® HCT *(esprosartan mesylate/hydrochlorothiazide tablets)*

Please check one:
- ❍ New Application
- ❍ Requesting Refill

❑ Please check box to indicate change of address	Name of Healthcare Practitioner:
Mailing Address:	Shipping Address: **(No P.O. Box)**
Suite/Floor:	Suite/Floor:
City: State: Zip Code:	City: State: Zip Code:
Office Contact Person:	
Office Telephone: ( ) Ext.:	Office Fax: ( )
Office Email Address:	Office Website Address:
Please provide your State Medical License #:	Expiration Date (mo/year):

By signing below, you the healthcare practitioner understand and agree that: Any medication(s) received from *Kos Pharmaceuticals, Inc. ("Kos" and "Kos Cares Patient Assistance")* are for the use of the patient named on this form, and shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I understand that *Kos Cares Patient Assistance* will send the medication to my office for dispensing to my patient. *Kos Cares Patient Assistance reserves the right at any time, and for any reason, to request additional information if needed and to suspend, discontinue, or otherwise revise the assistance provided under Kos Cares Patient Assistance which may include removing products from patient assistance program.*

Signature of Healthcare Practitioner **X** _____ Date _____

SECTION 2: ELIGIBILITY REQUIREMENTS* TO BE COMPLETED BY THE PATIENT

Please read the following eligibility requirements (check all that apply):
- Do YOU receive Medicaid or state-sponsored prescription drug assistance? ❑ **YES** ❑ **NO**
- Do YOU receive private, employee, military, retirement, or pension prescription drug benefits? ❑ **YES** ❑ **NO**

Please answer the following question:
- Are YOU enrolled in a Medicare Part D prescription drug plan? ❑ **YES** ❑ **NO**

* **Please note:** The program's eligibility requirements may change without notice.

SECTION 3: PATIENT FINANCIAL REQUIREMENTS TO BE COMPLETED BY THE PATIENT

The patient must attach copies of acceptable proof of income:

1) Federal Income Tax Return (Form 1040, 1040A, or 1040EZ) for the prior tax year, **AND**
2) All other current documents that provide proof of income paid to the patient (or the patient's spouse) such as:
   - Wage and Tax Statements (W-2 forms)
   - Social Security, Pension, or Railroad Retirement Statements (SSA-1099)

Proof of Income is required only once (1) per enrollment year.

If YOU did not attach a copy of YOUR Federal Tax Return, please verify by checking the box below whether YOU are required to file a return.

❑ **YES, I do file**
❑ **NO, I do not file**

What is the Total Number of Persons in Household? (including self):

(Circle one) 1 2 3 4 5 6 7 8

What is your Total Yearly Household Income?

$ _____ .00

If YOU cannot provide any proof of income, please call toll free **1-(866) 363-1024** for more instructions.

SECTION 4: TO BE COMPLETED AND SIGNED BY THE PATIENT OR LEGAL GUARDIAN

If you wish to receive notification of your medication shipment, please indicate by checking yes, and providing your mailing address below: ❍YES

Please Print: First Name:	Middle Initial:	Last Name:
Date of Birth (month/day/year):	Mailing Address:	
City: State:	Zip Code:	Daytime Telephone : ( )
Gender: ❍ Female ❍ Male		

By signing below, I verify that the information on this enrollment form including the signed copy of my most recent 1040 U.S. Federal Tax Return and the supporting proof of income , is complete and accurate. *All information provided to Kos Pharmaceuticals, Inc. ("Kos" and "Kos Cares Patient Assistance") will be kept strictly confidential and will not be sold, traded, or otherwise shared with other organizations. Kos Cares Patient Assistance reserves the right at any time, and for any reason, to request additional information and to suspend, discontinue, or otherwise revise the assistance provided under Kos Cares Assistance which may include removing products from patient assistance program.* I understand that I may revoke this consent and withdraw from participation in Kos Cares at any time, call toll free 1-(866)-363-1024.

Signature of Patient or Legal Guardian X _____ Date _____

KOS Cares™
Pioneering Medicines for a Better Life® Patient Assistance

Authorization to Disclose Information

Kos Pharmaceuticals, Inc. ("Kos" and "Kos Cares Patient Assistance") offers a Patient Assistance Program to help patients who qualify to be able to afford their medicines. I understand that Kos needs certain information about me to see if I qualify under the program for assistance in paying for: *(circle requested product)* Advicor®/Azmacort®/Cardizem® LA/Niaspan®/Teveten®/Teveten® HCT. I request and authorize my Healthcare Practitioner _____ ("Healthcare Practitioner") and my health insurance company _____ ("Insurer") to give Kos, including representatives who work on behalf of Kos in this Program, information about my health care treatment and insurance coverage. The type of information that may be given to Kos includes information that identifies me such as my name, date of birth, address, social security number, financial information, diagnoses, prior treatments and information about my health plan benefits. This information may include medical records, laboratory tests, hospital records, and Healthcare Practitioner's visit notes.

I know that I need to sign this authorization to take part in Kos Cares Patient Assistance. If I do not sign this authorization, my decision will not affect my ability to obtain treatment or seek payment for treatment. I also know that I can cancel this authorization at any time by writing to my Healthcare Practitioner and to Kos. Kos' contact person and address is: **Kos Cares Patient Assistance, Kos Pharmaceuticals, Inc., 2200 N. Commerce Parkway, Suite 300, Weston, FL 33326.** If I cancel this authorization, then my Healthcare Practitioner and Insurer will stop providing Kos with information about me. However, I cannot cancel actions that they have already taken by relying on my authorization.

I understand that once my Healthcare Practitioner and Insurer give Kos information about me based on this authorization, federal privacy laws may not prevent Kos from further disclosing my information. However, Kos has agreed that it will only use information about me to determine my eligibility for this program, to administer the program, and to account for my withdrawal if I decide to stop participating in this program. I also understand that signing this authorization does not guarantee that I will be able to receive: *(circle requested product)* Advicor/Azmacort/Cardizem LA/Niaspan/Teveten/Teveten HCT from Kos at a reduced or no cost. This authorization is good for as long as I participate in **Kos Care Patient Assistance.**

Patient or Personal Representative of Patient

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Name *(Please Print)* | Authority to Sign on Behalf of Patient *(If Applicable)*

3/2006