AZILECT®
P.O. Box 139
Somerville, NJ 08876

INSTRUCTIONS for AZILECT® (rasagiline tablets) Patient Assistance Program (PAP)

Phone: (866) 217-7163
Fax: (866) 838-5832

How to Apply:

Patient Instructions:

❑ Complete and sign page 1 (Patient Information).
❑ Attach copy of most recent Federal tax return.
- **If you do not file a Federal tax return, please attach other proof of yearly household income (such as W-2, 1099, unemployment award letter, social security, disability or pension statement) for everyone living with you.**
- If you have Medicare Part D drug coverage, attach a copy of the front and back of your Medicare drug card, and attach proof that you are in the coverage gap, such as a pharmacy printout that shows what you paid for AZILECT® and what your Medicare drug plan paid.

❑ Ask your doctor to complete and sign page 2 (Prescribing Practitioner Information).
❑ **Mail form and a copy of proof of income to:**

AZILECT® Patient Assistance Program, P.O. Box 139, Somerville, NJ 08876, or fax to 866-838-5832.

– If you have a Medicare Part D drug plan, include:
❑ copy of Medicare drug card
❑ pharmacy printout

Practitioner Instructions:

❑ Complete and sign page 2 Prescribing Practitioner Information (Practitioner section – no signature stamps, please).
❑ Either complete Prescription Information *OR* include an original prescription for a 3-month supply of AZILECT®.
❑ **All orders will be shipped to the patient, unless otherwise indicated.**
❑ If you are assisting a patient in completion of this form, please refer to patient instructions above.

Available Products	
AZILECT® 0.5 mg	AZILECT® 1.0 mg

Who Can Enroll (Program Eligibility):

❑ Patient must be a legal resident of the United States.
❑ Patient cannot have any private outpatient drug coverage for AZILECT®, such as an HMO or PPO plan.
❑ Patient with Medicare Part D drug coverage can enroll if patient is in the coverage gap ("donut hole"). Patient cannot have any other government drug coverage for AZILECT® such as Medicaid, Veteran's Administration, or any state or local program.
❑ Patient's yearly household income must be at or below 350% of the current Federal Poverty Level. See chart below for the income limit per household size:

Number of People in Household	Limit on Total Yearly Household Income
1	$41,580
2	$56,070
3	$70,560
4	$85,050
5	$99,540
6+	$114,030

How to get a Refill:

❑ The patient or practitioner may ask for a refill by phone. Call 866-217-7163, then press 4 and follow instructions.
OR
❑ The practitioner may submit a completed application to request a refill. **Refills do not require proof of income.**

How and When to Re-enroll:

❑ Medicare patients must send a new form each calendar year – when they enter the Part D coverage gap.
❑ To stay in the program, all other patients must send a new form every 12 months with proof of household income. Both patient and practitioner must complete and sign the form.

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APPLICATION FORM
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Patient Information

Name _____

Street Address _____
(No P.O. Box)

City_____State_____Zip_____

Social Security Number_____

Patient Gender: ❑ Male ❑ Female

Date of Birth _____

Phone # _____

Patient Representative For Purposes of Program (if applicable)
I permit the AZILECT® Patient Assistance Program to speak and write to the following person(s) about this form, and I permit the person(s) to sign any documents related to the Program on my behalf:

Name:_____ Relationship: _____Phone: _____

1. Is the patient a U.S. resident? ❑ Yes ❑ No

2. Does the patient have DRUG COVERAGE?
   - Private plan (such as HMO or PPO) ❑ Yes ❑ No
   - Medicare Prescription Drug ❑ Yes ❑ No If YES, when did patient enter coverage gap? (month)_____
   - Other Government coverage ❑ Yes ❑ No i.e.: Medicaid, Veteran's Administration, state or local programs

Drug plan name: _____Member ID and Group #: _____

3. What is the YEARLY HOUSEHOLD INCOME including wages, social security, disability, etc.? $_____YEARLY

4. How many people, including the patient, live in the household? (please circle) 1 2 3 4 5 6+

I attest that the above information is complete and accurate. I attest that I have no or insufficient prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program and I have insufficient financial resources to pay for the prescribed therapy. I understand and agree that PAP medication received will not count toward my true-out-of-pocket costs (TROOP) as defined under the Medicare Modernization Act. I understand that the PAP medication will be dispensed to me by my physician or will ship directly to my home and is provided at no charge to me or any other party; therefore, I agree that I will not submit any claim for the PAP medication to any third party, including my Medicare Part D Plan. By my signature, I authorize the release of the information about me and my medical condition to Teva Neuroscience and/or their agents. I authorize AZILECT® Patient Assistance Program and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment and administration of the program, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities Teva Neuroscience may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, AZILECT® Patient Assistance Program may request additional documentation to authenticate the statements made on my application. AZILECT® Patient Assistance Program and/or their agents agree to not disclose any information to any third party except those required for program administration as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice. The information above will append the incomplete information provided on my original enrollment application.

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

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Prescribing Practitioner Information

Patients Name _____ D.O.B. _____

Practitioner Name _____ Phone # (____) _____

Office Address _____ Fax# (____) _____

(Street Address Only)

City_____State_____Zip_____ Contact Person _____

NPI # _____ DEA or State License #:_____

SHIP ORDER TO: ❑ **Prescriber** or ❑ **Patient**

Prescription Information

Other Health Conditions:	**AZILECT®**	**Quantity:**	**Refills:**
Allergies: _____	Strength: ❑ **0.5 mg**	1 per day - max 90 days	1 year ❑
Other meds: _____	❑ **1.0 mg**	Is this a dosage increase from previous order? ❑ Yes ❑ No	

To the best of my knowledge the information contained in this application is complete and accurate and this patient has no or insufficient prescription insurance coverage either private or public (e.g. Medicaid), and meets the required income limits for participation in this Program. If I become aware of a change in income or insurance status that may affect Program participation of this patient, I will alert Program Sponsor. I understand that AZILECT® Patient Assistance Program reserves the right to modify or terminate this program at any time without notice. I attest that I am not on the HHS/OIG list of Excluded Individuals. My signature certifies that prescription products received from AZILECT® Patient Assistance Program will be used for the above named patient only and will not be resold nor offered for sale, trade or barter and will not be returned for credit. I agree to participate in any recall of the product initiated by the manufacturer.

_____

LICENSED PRACTITIONER SIGNATURE (NO SIGNATURE STAMPS, PLEASE) DATE