NOVARTIS

RabAvert® (Rabies Vaccine)
Patient Assistance Program

P.O. Box 42886 Cincinnati, OH 45242
Phone (800) 589-0837 Fax (513) 618-0056

Application Date: _____ _____ _____

SECTION 1 – PATIENT INFORMATION

Patient First Name _____ MI _____ Patient Last Name _____

Street Address _____

City _____ State _____ Zip _____

Social Security # _____ _____ _____ Telephone _____ Date of Birth _____ _____ _____

Spouse's Name _____ Spouse's Social Security # _____ _____ _____

Are you a veteran on the U.S. Armed Forces? ☐ Yes ☐ No Sex: ☐ Male ☐ Female

Are you a U.S Citizen or legal U.S. Resident? ☐ Yes ☐ No

This information MUST be provided for application to be considered.

PATIENT MUST ATTACH TAX FORM *or* IF TAX FORM NOT FILED, COMPLETE THIS SECTION AND ATTACH SUPPORTING DOCUMENTATION

Number of persons dependent upon primary income within family (including patient) _____

Annual Household Income $_____

Annual Physician Expenses $_____

Annual Prescription Expenses $_____

All Other Medical Expenses $_____

Unemployment or Disability $_____

Social Security $_____

Pension $_____

Investment Income $_____

Does the patient have ANY medical insurance? ☐ Yes ☐ No
(If patient is covered by federal or state program only, go to Federal or State Coverage Plans Section)

Is the patient covered under any other policy (i.e., family or friend)? ☐ Yes ☐ No

Part A - Medical Insurance
If you have answered yes to either of the above questions, please complete the following section. Include a copy of the patient's insurance card, front and back. If the patient has a prescription drug plan, include a copy of the plan card.

Company _____ Policy # _____ Phone _____

☐ HMO ☐ PPO ☐ Indemnity ☐ Champus ☐ VA ☐ Other (Please specify): _____

Date this coverage became effective: _____

Part B – Federal or State Coverage Plan(s)

If you participate in any federal or state medical reimbursement or assistance program, please complete this section. Include a copy of the patient's identification card, front and back.

Company _____ Policy # _____ Phone _____

☐ Medicare ☐ Medicaid ☐ State Assistance Program ☐ Local Assistance Program (ID # _____)

☐ Other (Please specify) _____

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PATIENT INFORMATION CONTINUED

Part C – Have you applied for Medicaid? ☐ Yes ☐ No

If yes, provide of date of application: _____ _____ _____

If no, please explain why patient has not applied: _____

If the patient's Medicaid application has been rejected, provide date and reason for rejection: _____

_____

Patient Certification: I certify that all the above statements and any information provided are correct and that I understand eligibility under this program are subject to Novartis's approval. I understand that Novartis has reserved the right to modify or terminate this program on sixty (60) days notice. I grant Novartis or its agents the right, at all times, to investigate any and all claims made under this program.

Patient Signature _____ **Date** _____ / _____ / _____

SECTION 2 – PRODUCT INFORMATION

Patient's need for RabAvert: ☐ Exposed to known or potentially rabid animal ☐ Exposed to known human rabies

If exposed to a known or potentially known rabid animal, please indicate type of animal:

☐ Dog ☐ Cat ☐ Bat ☐ Ferret ☐ Fox ☐ Livestock ☐ Raccoon ☐ Other (please list) _____

Suspected exposure date _____ _____ _____

Has the patient previously received any type of rabies vaccination? ☐ Yes ☐ No

If yes, physician should contact local public health officials regarding appropriate prophylaxis regimen.

Rabavert Treatment Dates: 1st injection _____ _____ _____ 2nd injection _____ _____ _____

3rd injection _____ _____ _____ 4th injection _____ _____ _____ 5th injection _____ _____ _____

Number of vials required: _____

SECTION 3 – PHYSICIAN INFORMATION

Physician First Name _____ MI _____ Physician Last Name _____

Street Address _____

City _____ State _____ Zip _____

DEA Number _____ State License Number _____

Telephone _____ Fax _____ Office Contact _____

I attest that the information provided is accurate to the best of my knowledge and agree to accept the medication being shipped to the office above for dispensing.

Physician Certification: I understand that I agree to follow this patient through his/her entire course of RabAvert treatment. I understand that I will be sent RabAvert vials immediately and if I have not provided all requested documentation in a timely manner to Novartis or it's agents regarding RabAvert therapy for this patient that I will be invoiced for the RabAvert.

Physician Signature _____ **Date** _____ / _____ / _____

ALL MEDICATIONS WILL BE SHIPPED TO THE PHYSICIAN'S OFFICE

Physicians can apply online at www.RxHope.com