Meda Patient Assistance Program
PO Box 42886 - Cincinnati, OH 45242
Phone: 800-593-7923 - Fax: 513-618-0053
Physicians can apply online at www.RxHope.com/Meda

ELIGIBILITY REQUIREMENTS

- **Application must be filled out in its entirety by the Patient and Healthcare Provider**
- **Patient and Healthcare Provider must sign and date the application**
- **Patient must have a gross annual household income that is at or below 300% of the Federal Poverty Level.**
- **Patient must not have coverage through any Medicaid, Medicare, Medicare Part D or Private Insurance**

INCOME VERIFICATION

- **Patient must attach a copy of the most recent household income documentation**

  Acceptable forms of documentation include:
  - **Copy of U.S. Income Tax Return, IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040 PR**
  - **Copy of Social Security/Disability Award Letter, Benefit Statement, or Monthly Check**
  - **Copy of most recent pay stub**
- **If the patient is unable to provide documentation of income, the Healthcare Provider may attest to the patient's need by attaching a letter stating that patient has no income and is unable to afford the requested medication.**

Meda Patient Assistance Program
PO Box 42886 - Cincinnati, OH 45242
Phone: 800-593-7923 - Fax: 513-618-0053
Physicians can apply online at www.RxHope.com/Meda

PHYSICIAN INFORMATION

Physician Name (Last, First, MI) ______________________ Designation __________

State License # ______________________ Expiration Date ______________________

Address ______________________

City ____________ State ________ Zip Code __________ Email ______________

Telephone ______________ Fax ______________ Contact ______________

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature ______________________ Date ______________

PRODUCT INFORMATION

Felbatol® (felbamate)

☐ 400mg tablets
Times per day ______

☐ 600mg tablets
Times per day ______

☐ 600mg/5mL Oral Suspension
Times per day ______

PATIENT INFORMATION

Patient First Name ______________ MI ______ Last Name ______________

Address ______________________ City ______________

State _________ Zip ___________ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other

Telephone ______________ Date of Birth (MM/DD/YYYY) ______________ ☐ Male ☐ Female

Social Security # ______________ Are you a U.S. Resident? ☐ Y ☐ N Are you a Veteran? ☐ Y ☐ N

Number of Persons in Household _____ Household Gross Income* $ ______________

*Documentation Required. See Instructions Sheet for Acceptable Proof of Income Documentation

Do you have Prescription Drug Coverage? ☐ Yes ☐ No Are you enrolled in Medicaid? ☐ Yes ☐ No

Are you enrolled in Medicare Part D? ☐ Yes ☐ No

I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive 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 certify that I shall not seek reimbursement for any medication dispensed as part of the program. I hereby authorize the patient assistance program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature ______________________ Date ______________