Azilect® Patient Assistance Program
P.O. Box 139
Somerville, NJ 08876
Phone (866) 217-7163
Fax (866) 838-5832

AZILECT®
(rasagiline tablets)

PATIENT SECTION (Patient must complete this section.)

NAME:	SOCIAL SECURITY #:
ADDRESS:	
CITY:	STATE: ZIP CODE:
DATE OF BIRTH:	PHONE NUMBER:
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE WITH: MEDICAID: YES ☐ NO ☐ VETERAN'S ADMINISTRATION: YES ☐ NO ☐	
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE WITH MEDICARE:	YES ☐ NO ☐
DOES THE PATIENT HAVE PRESCRIPTION COVERAGE WITH ANY PRIVATE PROGRAM: (This includes coverage through any private insurance, HMO or PPO)	YES ☐ NO ☐
IF THE PATIENT HAS PRESCRIPTION COVERAGE, DOES IT COVER AZILECT:	YES ☐ NO ☐ N/A ☐
IS THE PATIENT A LEGAL UNITED STATES RESIDENT:	YES ☐ NO ☐
THE PATIENT'S TOTAL **ANNUAL** HOUSEHOLD INCOME INCLUDING SOCIAL SECURITY & PENSION BENEFITS IS $ _____	
THE NUMBER OF RESIDENTS IN THE PATIENT'S HOUSEHOLD IS (Check box)	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ ☐

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to Teva Neuroscience, Inc., and their agents, all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the Azilect® Patient Assistance Program. I also authorize Teva Neuroscience, Inc., and their agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate and I have no prescription insurance coverage, including all public programs, and have insufficient financial resources to pay for the prescribed therapy. I understand that Teva Neuroscience, Inc. reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize Teva Neuroscience, Inc. to use my Social Security number for identification purposes and record keeping only.

Patient's Signature Date

LICENSED PRACTITIONER SECTION (Licensed practitioner must complete this section.)

NAME:	PROFESSIONAL DESIGNATION: (MD, DO, etc.)
OFFICE ADDRESS: *(No P.O. Box)*	
CITY:	STATE: ZIP CODE:
PHONE #:	FAX #:
DEA#: *(If you do not have a DEA# please **attach** a copy of your current state license)*	
ME #:	
CONTACT PERSON IN OFFICE:	OFFICE PHONE #:

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Teva Neuroscience, Inc. reserves the right to modify or terminate this program at any time. I understand Teva Neuroscience, Inc. reserves the right to recall the product when necessary.

Original Signature of Licensed Practitioner (No stamped signatures or photocopies) Date

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