TevaCares FOUNDATION

PO Box 52028 ◆ Phoenix, AZ 85072
Phone: 877-237-4881 ◆ Fax: 877-438-4404

Thank you for your interest in the TEVA CARES FOUNDATION Patient Assistance Program which provides prescription medicines at no cost to patients who qualify. If you have no prescription drug coverage and meet the income guidelines below, you may qualify for this program. Please complete and submit this application to determine if you qualify. Each application will be considered on a case by case basis.

Income Guidelines

Number of people in your household	Total yearly income
1 person	$35,310
2 people	$47,790
3 people	$60,270
4 people	$72,750
5 people	$85,230

INSTRUCTIONS (An incomplete application will delay processing)

Patient:

1. Complete **ALL** fields on page one.
2. Read the consent language and sign the application at the bottom of page one.
3. Complete the product shipment information on page two.
4. Attach copies of proof of income:
   - A copy of your most recently filed Federal Income Tax Return **OR** a Social Security Income Yearly Benefits Statement.
   - Proof of income is required from all sources and for all household members.
5. Coordinate with your physician to fax or mail the completed application and proof of income as described below.

Physician:

1. Complete the Prescription information section on page two. Attach a separate prescription if required by your state's prescription laws.
2. Read the consent language and sign the application as indicated on page two.
3. If a prescription is faxed, it must be sent directly from the physician's office.
4. Fax or mail the completed application and proof of income as described below:

   Fax to **1-877-438-4404** or mail to:

   TEVA CARES FOUNDATION
   Patient Assistance Program
   PO Box 52028
   Phoenix, AZ 85072

5. For additional Fentora and Nuvigil prescription instructions, please see page 2 of the application.

If you have any questions please call the program at **877-237-4881**. We are available to answer your call Monday through Friday, from 9:00am to 8:00pm Eastern Time (excluding holidays).

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Application Form

PO Box 52028 ◆ Phoenix, AZ 85072 ◆ Phone: 877-237-4881 ◆ Fax: 877-438-4404

PATIENT INFORMATION:

Patient Name (First MI Last): _____

Social Security #: _____ Date of Birth: _____

Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Contact Name (if other than patient): _____ Contact Phone: _____

Permanent US Resident? ❑ YES ❑ NO Gender: ❑ Male ❑ Female

FINANCIAL INFORMATION:

Number of people in your household (including you, your spouse and your dependents) _____

Total yearly income for your household listed above (Adjusted Gross Income) $_____

You must provide proof of income to apply for this program. Provide either a copy of your most recently filed Federal Income Tax Return OR a Social Security Income Yearly Benefits Statement. Proof of income is required from all sources for all household members.

INSURANCE INFORMATION:

Do you have any insurance coverage? ❑ YES ❑ NO

For each policy you have, including any secondary coverage, provide the following:

	Insurance Name:	Phone #:	ID / Policy #:
Primary:			
Secondary:			

Please provide legible copies of the front and back of all insurance cards (enlarged if possible)

Do you have the following insurance coverage?

Employer provided or other private insurance ❑ YES ❑ NO
Medicare A or B **If yes**, list Effective Date: _____ ❑ YES ❑ NO
Medicare Advantage ❑ YES ❑ NO
Medicare Part D ❑ YES ❑ NO
Medicaid ❑ YES ❑ NO
What is your Medicaid status? ❑ Not applied ❑ Denied ❑ Pending
State Assistance Program ❑ YES ❑ NO
Veterans ❑ YES ❑ NO
Are you a Veteran? ❑ YES ❑ NO
If yes, have you applied for VA benefits? ❑ YES ❑ NO
Other insurance ❑ YES ❑ NO

CONSENT:

I promise that the information provided in this application is current, complete, and accurate. I agree to notify the TEVA CARES FOUNDATION (THE FOUNDATION) as soon as possible if my employment or insurance status changes. I agree that my doctors, pharmacists, insurance companies, employers, THE FOUNDATION and their agents and others may share all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my enrollment or participation in the TEVA CARES FOUNDATION Patient Assistance Program. I give THE FOUNDATION and their agents permission to contact me in connection with this program. I understand that completing this application does not guarantee acceptance into the Program. I understand that the THE FOUNDATION reserves the right to modify or discontinue this Program at any time without prior notice and reserves the right to recall the product when necessary. I promise that I have not received, and will not seek to receive, insurance reimbursement for any drug I request or receive as part of the TEVA CARES FOUNDATION Patient Assistance Program. I understand that I can withdraw from the Program at any time by notifying THE FOUNDATION in writing at the address above. I agree that a photocopy or faxed copy of this consent may be used in place of the original.

➔ **Patient/Legal Guardian* Signature: _____ Date: _____**

** Please provide a description of the Legal Guardian's authority to act for the patient.*

Teva Cares Foundation Application Form

PO Box 52028 ◆ Phoenix, AZ 85072 ◆ Phone: 877-237-4881 ◆ Fax: 877-438-4404

Prescriber: Please attach a separate prescription if required by your state's prescription laws.

PRESCRIPTION:

Patient Name (First MI Last): _____ **Date of Birth:** _____

Address: _____

City: _____ State: _____ Zip: _____

Health Conditions: _____

Medication Allergies: _____

Medications Currently Taking: _____

❑ **Ship to Patient** ❑ **Ship to Office** *If shipping address is different than the address provided, list below.*

Medication Shipping Address: _____

City: _____ State: _____ Zip: _____

Medications Available: Cyclosporine Capsules Modified, Cyclosporine Oral Solution Modified, GABITRIL®, GALZIN®, ORAP®, ProAir HFA®, Proglycem®, QNASL™, QVAR®

Product Requested:	Strength:	Quantity:	Frequency/Directions:	Refills:
❑ _____ 90 day supply				❑ None ❑ 1 Year
❑ **TEV-TROPIN®** 30 day supply				❑ None ❑ 1 Year

TEV-TROPIN®, check supplies needed: Refill Supplies: ❑ None ❑ 1 Year

❑ DILUENT SYRINGE - BD LL 3ML/21G QUANTITY FOR 30 DAY SUPPLY: _____

❑ INJECTION SYRINGES - BD ULTRA FINE: ❑ .3ML/31G ❑ .5ML/30G ❑ 1ML/31G QUANTITY: _____

❑ ALCOHOL SWABS (100 ct) ❑ SHARPS CONTAINER

❑ INJECT-EASE® ❑ TJET™ INJECTION DEVICE ❑ NEEDLE FREE HEADS ❑ VIAL ADAPTOR

Signature Required → **Prescriber's Signature:** _____ **Date**:_____

Physician Name: _____ DEA #:* _____

NPI #: _____ Medical License #: _____

Facility Name: _____ Tax ID: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Medicaid Provider # & Pin: _____ BCBS Provider #: _____

Clinic Contact: _____ Contact Title: _____

Contact Phone: _____ Ext: _____ Contact Fax: _____

*Required for Class IV (NUVIGIL®) and Class II (FENTORA®) medications

Medications Requiring a Separate Prescription

❑ **FENTORA®CII** 28 day supply ❑ **NUVIGIL®CIV** 90 day supply – with 1 refill	A separate prescription for Fentora or Nuvigil should be mailed directly to: MedVantx, C/O Teva Cares Foundation, 2503 E 54th St N, Sioux Falls, SD 57104 ◆ Fentora: To request a refill, a hard copy prescription is required each month ◆ Nuvigil: Prescriptions may also be faxed to 855-693-7844. Please mail your Nuvigil prescription if your state's requirement does not allow for faxes.

On behalf of my patient, I request assistance for the drug specified in this application. I attest that the information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed the drug specified in this application based on my professional judgment of medical necessity. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested and/or supplied under the Program. I certify that no free product provided under this Program will be distributed for sale or returned for credit. I understand that the TEVA CARES FOUNDATION reserves the right to modify or terminate this Program at any time without prior notice and reserves the right to recall the product when necessary. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug.

Signature Required → **Prescriber's Signature:** _____ **Date**:_____