PATIENT ASSISTANCE PROGRAM

PHONE: (888) 958-5502 | FAX: (888) 958-1725

PATIENT ASSISTANCE PROGRAM ELIGIBILITY AND GUIDELINES

- The application must be completed in its entirety
- FAX the application with requested documentation to the fax number above
- The patient must be a U.S. Resident with a valid Social Security Number
- The patient must have a household income at or below 300% of the current Federal Poverty Level
- The patient must not have prescription insurance coverage, or must be underinsured as defined by the program
- Patients who meet certain rules will be able to get their prescribed medications free of charge for up to one year
- Every year, the patient must reapply, and be accepted, to continue in the program

FOR THE HEALTHCARE PROVIDER

- The application must be completed with an original signature. Stamp signatures are not accepted.

FOR THE PATIENT

- The application must be completed in its entirety with an original signature and date.
- You must reapply to the program annually, including the completion of a new application with a new original signature and date

Phone: (888) 958-5502 | **Fax**: (888) 958-1725 | **Hours**: 8am – 5pm CST, M-F

Patient Assistance Program

Please complete form in full, sign and date, and fax to **(888) 958-1725**

Patient Information

Name: _____ Date of Birth: ____/____/____ SSN: ___ – ___ – ___ Gender: ☐ Male ☐ Female
First Middle Last (Required)

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Are you a US Resident? ☐ Yes ☐ No

Total Annual Household (HH) Income: $ _____ Household Size (circle selection): 1 2 3 4 5 6 _____

Insurance Information

Please Select Your Pharmacy Insurance Coverage Type: *(select all that apply, please provide copies of insurance cards with the application)*

☐ Private/Commercial ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA or Military ☐ No Pharmacy Benefit ☐ No Insurance (Uninsured)

Pharmacy Plan Name: _____ Phone: _____ Pharmacy ID/Policy#: _____

BIN: _____ PCN: _____ Rx Group: _____ Policyholder Name & DOB: _____
(If other than patient)

Patient Authorization & Signature

I, the applicant named below, understand that I am providing 'written instructions' to Horizon Pharma and its vendor Sonexus Health, LLC under the Fair Credit Reporting Act authorizing Sonexus Health, LLC on behalf of Horizon Pharma to obtain information from my credit profile or other information from Experian Health. I authorize Horizon Pharma and its partnered provider Sonexus Health to obtain such information solely for determining financial qualifications for the Horizon Pharm Patient Assistance Program (PAP). I understand that I must affirmatively agree to the terms in this notice by signing below to proceed in the PAP financial screening process.

I certify that the information provided on this application 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. I understand that I am entitled to a copy of this authorization upon request, and that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Horizon Pharma, c/o Sonexus Health 1330 Enclave Parkway, Ste. 125 Houston, TX 77077, but that this cancellation will not apply to any information already used or disclosed through this authorization.

Patient Authorization: *My signature certifies that I have read and understand the above statements, and agree to the outlined terms.*

Patient Name (Print): _____ Patient Signature: _____ Date: _____

Prescriber Information

Prescriber Name: _____ Prescriber NPI: _____

Facility Name: _____ State License #: _____

Facility Address: _____ City: _____ State: _____ ZIP: _____

Primary Office Contact: _____ Fax Number: (____) _____

Phone Number: (____) _____ Office Contact Email: _____

Prescription & Diagnosis Information

Product	Dose	Quantity	Refills	SIG
☐ **RAYOS®** (prednisone) delayed-release tablets	☐ 1 mg ☐ 2 mg ☐ 5 mg	30 day supply	11	
☐ **VIMOVO®** (naproxen and esomeprazole magnesium) delayed-release tablets	☐ 375 mg/20 mg ☐ 500 mg/20 mg	30 day supply	11	
☐ **DUEXIS®** (ibuprofen and famotidine) tablets	800 mg/26.6 mg	30 day supply	11	
☐ **PENNSAID®** (diclofenac sodium topical solution) **2%** w/w	40 mg (2 pump actuations), 2 times a day	1 bottle	11	

Allergies: _____ ☐ No Known Allergies Other Medications: _____

Diagnosis: (include diagnosis description) _____

Prescriber Certification & Prescription Signature

By signing this prescription, I certify that I have prescribed the requested Horizon Pharma medication to treat this patient for an indication that is within the medication's approved labeling, and that I will supervise the patient's medical treatment. I certify that the information provided is complete and accurate to the best of my knowledge, and that I shall not seek reimbursement for this medication from any third party.

Prescriber Signature: _____ Date: _____

*(original signature required - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*