

Patient Assistance Program Policy and Instructions

The Romark Patient Assistance Program is designed to assist financially disadvantaged individuals. All applications are reviewed on a case-by-case basis. Eligibility is based on current Federal Poverty Guidelines adjusted for household size. The provision of free medication is a philanthropic activity sponsored by Romark Laboratories, L.C. Therefore, the Romark Patient Assistance Program is considered the payor of last resort.

Enrollment

Please complete the entire application. Failure to complete any section or to provide all required documentation will delay the review process. Incomplete applications will be returned for further information.

Physician Information Section: To be completed by the physician or office staff.

Patient Information Section: To be completed by the patient or legally authorized representative.

1. Monthly household income is required. You must report all income, including salary, pension, Social Security, etc. for all members in the household.
2. A letter of Medicaid, Social Security, and/or AIDS Drug Assistance Programs (ADAP) denial or Qualified Medicare Beneficiaries (QMB) statement is required, if applicable.
3. Please carefully review the patient consent form.
4. Patient or legally authorized representative's signature and date are required. Please provide documentation of authorization if signing for patient.

Prescription Information Section: To be completed by the physician. Please carefully review the consent and then sign and date the application – no stamps will be accepted.

Please ensure that the application is complete. Fax **OR** mail the completed application and associated documentation to Romark Laboratories, L.C. to the fax number or mailing address above for eligibility review.

Approval & Shipment

The physician's office and patient will be notified of patient eligibility. Upon approval into the Romark Patient Assistance Program, a supply of medication will be shipped to the physician's office for dispensing to the patient.

Questions & Comments

Please contact us:

Phone: (813) 282-8544

Fax: (813) 282-1162

Hours: Mon-Fri 8:30am-5:30pm EST



Romark Patient Assistance Program for Alinia®
 3000 Bayport Drive, Suite 200
 Tampa, FL 33607
 Phone (813) 282-8544 Fax: (813) 282-1162

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
 Address (No P.O. Box): _____
 City: _____ State: _____ Zip: _____
 Social Security #: _____ Sex: O M O F Date of Birth: _____ Phone: _____ Fax: _____
 Household Income –Monthly (Income must include all in household): _____
 Source of Income: _____ # in household: _____
 Does the patient have any form of third party prescription drug coverage (partial or full) for the product requested?
 Medicare O Yes O No Private insurance/HMO O Yes O No
 Medicaid O Yes O No Other state/governmental program O Yes O No
 Has the patient applied for financial assistance (Medicaid, ADAP, SS, etc.)? O Yes O No
 If *yes*, has the patient been denied assistance: O Yes O No O Pending O Waitlisted O QMB (If *yes*, provide copy of denial QMB statement.)

Patient Consent for Use and Disclosure of Information

I request and authorize the physician named above to release to Romark Laboratories, L.C., or third parties contracted by Romark Laboratories, L.C. in connection with the Romark Patient Assistance Program (collectively “Romark”), all information regarding my health and treatment, or that of the above patient for whom I am the legally authorized representative, pertaining to the requested medication named below. This authorization shall be valid for one year from the date it is signed. Except to the extent that this authorization has been relied upon by Romark and the physician named above, I may revoke this authorization by writing to them. I understand that information provided to Romark pursuant to this authorization may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) and may, therefore, be redisclosed. Romark will use and disclose such information to assist with the assessment of my eligibility for and enrollment in the Romark Patient Assistance Program, to account for my withdrawal if I decide to stop participating in this program, and as required by law. I understand that this authorization is not a condition for health care treatment and does not guarantee eligibility into or no cost medication for the Romark Patient Assistance Program.

In the event that I am eligible for the Romark Patient Assistance Program, I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that this program may be changed or discontinued at any time. I attest that the information I have provided is correct and complete. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer.

I also authorize Romark to use the information I have given for internal review and analysis and to provide me with helpful information.

 Patient or Legally Authorized Representative’s Signature Date

PHYSICIAN INFORMATION

Patient Number: _____ (please assign a unique non-SS number for your patient)
 Physician’s Name: _____ Professional Designation: _____
 Office/Building Name: _____ Address (No P.O. Box): _____
 City: _____ State: _____ Zip: _____
 State License #: _____ (A copy of the State License must accompany this application)
 Office Contact: _____
 Office Phone #: _____ Ext: _____ Fax: _____

PRESCRIPTION INFORMATION

Alinia® Requested:
 O Check here for one (1) 60ml bottle, Alinia® (nitazoxanide) Suspension, 100mg/5ml (67546-212-21PAP)
 O Check here for one (1) tray of 5 cartons with 2 tablets each - 10 total tablets, Alinia® (nitazoxanide) Tablets, 500mg – PROFESSIONAL SAMPLES (67546-111-37PAP)
 O Check here for one (1) 30 count bottle, Alinia® (nitazoxanide) Tablets, 500mg (67546-111-12PAP)

Signature: _____

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that Romark Laboratories, L.C. will send the medication to my office for dispensing to my patient. Romark Laboratories, L.C. reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for a patient participating in the Romark Patient Assistance Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer.

 Physician’s Signature (STAMPS NOT ACCEPTED) Specialty Date