SOLVAY PHARMACEUTICALS
P.O. Box 66550
St. Louis, MO 63166-6550
1-800-256-8918

Patient Assistance Enrollment Application

HEALTHCARE PROVIDER INFORMATION

DEA/State License #r: Physician Name: (First) (Last)

Address: City: State: Zip:

Office Contact: Phone: ( ) Fax: ( )

MEDICATION INFORMATION – Please complete Prescription/Order Form on second page

Requested product: ❑ AndroGel®

The product listed above must be shipped to the patient's address

❑ ACEON® ❑ CREON® ❑ ESTRATEST® ❑ PROMETRIUM®

The products listed above may be shipped to either:
Licensed Prescriber's Office ☐ Patient's Address ☐

Patient diagnosis (ICD.9 code) :

My signature below certifies that the person named on this form is my patient and medications received from Solvay for patient assistance are only for the use of this patient's medical treatment in which I will be supervising. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor returned for credit. By signing, I also agree that Solvay has the right to contact my patient directly to confirm receipt of medications, and to revise, change, or terminate this program at any time. To the best of my knowledge, my patient meets Solvay's criteria for this program. The enclosed application must be filled out completely and signed by a licensed practitioner (an MD or DO, or a Nurse Practitioner or Physician Assistant in those states where NPs and PAs are authorized to write prescriptions).

Signature of Physician:
X

Date

PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line.

Social Security / ID No: Patient Name: (First) (Last)

Address: Home Phone: ( ) Work Phone: ( )

City: State: Zip:

County: US Resident: ❑ Yes ❑ No Date of Birth: ____/____/_____ Gender: ❑ Male ❑ Female

Veteran: ❑ Yes ❑ No Disabled: ❑ Yes ❑ No

Patient Language: ❑ English ❑ Spanish ❑ Other: _____

Is this patient an in-patient or out-patient?: ❑ In-patient ❑ Out-patient If an in-patient, please explain: _____

FINANCIAL INFORMATION – Please attach a copy of household's most recent year tax return (1040, 1040EZ, 1099, etc.)

Total # of people in household (include self): _____

Total Assets per Household:
Includes bank account, IRA, annuity, stocks, bonds, etc.

LIST ALL SOURCES OF GROSS MONTHLY AMOUNTS PER HOUSEHOLD

Salary/Wages (All Sources)	$	Disability	$
Pension/Retirement	$	Alimony/Child Support	$
Social Security	$	Unemployment Compensation	$

ATTACH PROOF OF INCOME

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Total Gross Monthly Household Income:

INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)

	Medical Coverage (circle one)	Prescription Drug Coverage for Requested Product (circle one)	Eligibility Status E=Eligible P=Pending I=Ineligible (reason)	Policy Number	Phone Number	Contact Person
Medicare	Y N	Y N			( )	
Medicare Part D	Y N	Y N			( )	
Medicaid	Y N	Y N			( )	
Private Insurance	Y N	Y N			( )	
ADAP	Y N	Y N			( )	
State Elderly Drug Assistance	Y N	Y N			( )	
State Children Health Insurance	Y N	Y N			( )	
Veterans Assistance	Y N	Y N			( )	
Other:	Y N	Y N			( )	

APPLICANT DECLARATION

I attest that the information included in this application is correct and complete. I understand that the information on this enrollment form and my prescription for this product will only be used for purposes of determining eligibility and administering the Solvay Patient Assistant Program. I further understand that documentation is requested to verify financial or insurance information. I understand that assistance in the form of free drug is contingent upon my ability to meet the program eligibility criteria, and Solvay Pharmaceuticals reserves the right, at any time without notice to modify or discontinue this program and its eligibility criteria. I authorize the Solvay Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources, as deemed necessary, to ensure the accuracy and completeness of this application and to provide services through this program.

Signature of Patient or Legal Guardian:
X

Date:

SOLVAY PHARMACEUTICALS

Prescription and Order Form

P.O. Box 66550
St. Louis, MO 63166-6550
1-800-256-8918

Section 1 - Physician and Prescription Information			
Physician Name:	DEA/State License #:	Phone: ( )	Fax: ( )
Address: (no P.O. Box)	City:	State:	Zip:

Prescription	Instructions	Quantity	Day Supply	Refills
AndroGel® 1% Topical (maximum daily dose 10 gms) ☐ 30 packets per box ☐ 2x75gm pump (1 metered dose is 1.25gm) Strength: ☐ 2 .5gm ☐ 5 gm			☐ **30** ☐ **60** ☐ **90**	

Enclose a copy of a government issued ID when ordering the products listed above: Driver License, State ID, Military ID, etc.

The products listed above must be shipped to the patient's address

Physician Signature:
(must be MD / DO no PAC / NP) _____ ____/____/____ _____
(dispense as written) (date) (substitution allowed)

The products listed below may be shipped to patient's address or healthcare provider's office; if not indicated medications will be shipped to patient's address.

Medication should be sent to: Licensed Prescriber's Office ☐ **Patient's Address** ☐

Product Requested	Instructions	Quantity	Bottles Req.	Refills
ACEON® (perindopril erbumine) Tablets ☐ 2MG ☐ 4MG ☐ 8MG			☐ **100**	
CREON® MINIMICROSPHERES® (pancrelipase) DR Capsules ☐ 5MG ☐ 10MG ☐ 20MG			☐ **100**	
ESTRATEST® (esterified estrogens, UPS 1.25mg & methyltestosterone,2.5mg) Tablets			☐ **100**	
ESTRATEST®HS (esterified estrogens, USP 0.625mg & methyltestosterone,1.25mg) Tablets			☐ **100**	
PROMETRIUM® (progesterone, USP) ☐ 100MG ☐ 200MG			☐ **100**	

Physician Signature:
_____ ____/____/____ _____
(dispense as written) (date) (substitution allowed)

Section 2 - Patient Information			
Patient Name:			SS #, Green Card, VISA:
Street Address:			Date of Birth:
City:	State:	Zip:	Phone: ( )

Medication Information

Patient allergies: ☐ No Known _____

Please list the names of other medications the patient is currently taking: ☐ None _____

If you are a New York prescriber, please use an original New York State Prescription Form.
Please fax this form to 1-800-276-9901 or mail to address above