Patient Assistance Program Application

VALEANT
PATIENT ASSISTANCE PROGRAM

Thank you for your interest in the Valeant Patient Assistance Program (Valeant PAP).

This program is designed to provide assistance and access to individuals in need of products made available through the Valeant PAP. All applications are reviewed on a case-by-case basis and there is no cost to apply. If approved, you may be able to receive product through this program for up to one year, as long as you remain eligible and a valid prescription remains on file.

You may be eligible for the program if you:

- Are a legal United States resident
- Have a valid prescription from a licensed U.S. healthcare professional for a product made available through the Valeant PAP
- Do not have insurance coverage for the prescribed Valeant product
  - Patients with Medicare Part B or Medicare Part D coverage may request an appeal to be evaluated for Valeant PAP eligibility if they meet all other program guidelines
- Are being treated as an outpatient
- Meet the pre-defined eligibility requirements and total annual household income requirements

For full eligibility requirements, please visit **ValeantPAP.com**.

Participating Valeant Pharmaceuticals companies include:

BAUSCH + LOMB Ortho Dermatologics Salix Pharmaceuticals VALEANT Pharmaceuticals North America LLC

Submitting an Application

Patient Instructions

1. Complete the Patient Information and Insurance Information Sections on page 1.
2. **Read and sign the Patient Authorization and Certification on page 2.**
3. Have your prescriber complete pages 3 and 4 and sign Prescriber Certification on page 4.
4. If applicable, attach a copy of your medical and prescription insurance cards.

Prescriber Instructions

1. Complete Product Information and Prescriber Information on pages 3 and 4.
2. **Sign Prescriber Certification on page 4.**
3. Attach original valid prescription(s) with physician signature. Stamped signatures are not allowed for controlled substances.

   Special note: New York prescribers must submit the patient's prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank, if applicable for your state. **Faxed prescriptions must be faxed from the prescriber's office.**
4. Have patient complete pages 1 and 2.

Mail or fax the completed application form, requested documentation, and signed original prescription to:

VALEANT PATIENT ASSISTANCE PROGRAM
P.O. BOX 429303, Cincinnati, OH 45242-9303
PHONE 833-862-VPAP (833-862-8727)
FAX 866-777-5705

For questions about the program or how to complete this application, please contact the Valeant Patient Assistance Program at 833-862-VPAP (833-862-8727), Monday through Friday, 8:00 AM to 5:00 PM Eastern Time.

Patient Assistance Program Application

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PATIENT ASSISTANCE PROGRAM

To be completed by the Patient

Please print clearly. All items must be completed or application will be returned. If something does not apply, please write N/A.

☐ Complete the Patient Information and Insurance Information Sections on page 1.

☐ **Read and sign the Patient Authorization and Certification on page 2.**

☐ Have your prescriber complete pages 3 and 4 and sign Prescriber Certification on page 4.

☐ If applicable, attach a copy of your medical and prescription insurance cards.

Mail or fax the completed application form, requested documentation, and signed original prescription to
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For questions about the program or how to complete this application, please contact the Valeant Patient Assistance Program at 833-862-VPAP (833-862-8727), Monday through Friday, 8:00 AM to 5:00 PM Eastern Time.

1 Patient Information (*Required)

*First Name _____ *Last Name _____

*Street Address _____

*City _____ *State _____ *ZIP Code _____

*Primary Phone # _____ ☐ Home ☐ Mobile Secondary Phone # _____ ☐ Home ☐ Mobile

Best Time to Call _____ *Is it ok to have a pharmacist contact you? ☐ Yes ☐ No

*Social Security or Green Card # _____ *U.S. Resident ☐ Yes ☐ No Gender ☐ M ☐ F

Email _____ *Date of Birth _____

*Check Number of People in Household (include self) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ *Annual Household Income $ _____

2 Insurance Information (Select all that apply and, if applicable, attach a copy of your medical and prescription insurance cards)

☐ **I Do Not Have Health Insurance** (if checked, go to Section 3)

☐ **Private Insurance** (such as HMO or PPO) Does your policy include Prescription Drug Coverage? ☐ Yes ☐ No

Insurer Name _____ Insurer Phone # _____

Cardholder Name _____ Cardholder date of birth _____

Relationship to Cardholder _____ Group ID # _____

Policy ID # _____ Rx BIN # _____ Rx PCN # _____

☐ **Medicare** (select all that apply)

Medicare Part A? ☐ Yes ☐ No **Medicare Part B?** ☐ Yes ☐ No **Medicare Part C** (Medicare Advantage)? ☐ Yes ☐ No

Insurer Name _____

Insurer Phone # _____ Medicare Policy ID # _____

Medicare Part D? ☐ Yes ☐ No If you received a denial letter for Low Income Subsidy, please attach a copy with your application.

Part D Plan Name _____ Part D Plan Phone # _____

Part D Policy ID # _____ Rx BIN # _____ Rx PCN # _____

☐ **Other Government Insurance**

Medicaid? ☐ Yes ☐ No Veterans Affairs (VA) Benefits? ☐ Yes ☐ No

State Elderly Drug Assistance? ☐ Yes ☐ No Other State/Federal Patient Assistance Program? ☐ Yes ☐ No

Plan Name _____ Phone # _____

Policy ID # _____ Rx BIN # _____ Rx PCN # _____

Any other benefit program that helps pay for prescription drugs? ☐ Yes ☐ No

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To be completed by the Patient

3 Patient Authorization and Certification (Patient must read and sign below)

I hereby consent to allow Valeant Pharmaceuticals, and its affiliates, agents, and contractors, including the administrator of the Valeant PAP, the dispensing pharmacy or distributor of Valeant products (collectively, "Valeant") to use and/or disclose the information in this form and my dispensing information to any third party engaged to assist Valeant in the administration of the Valeant PAP. I understand that this information will be used to determine my eligibility for participation in the Valeant PAP and to administer the program, except as may be required or permitted by applicable law, and that Valeant reserves the right at any time for any reason to contact me and to request additional information. I, the applicant named below, understand that I am providing 'written instructions' to Valeant and its vendor, Triplefin LLC, under the Fair Credit Reporting Act authorizing Triplefin LLC on behalf of Valeant to obtain information from my credit profile or other information from Experian Health or any other credit reporting agency. I authorize Valeant and its partnered provider, Triplefin LLC, to obtain such information solely for determining financial qualifications for the Valeant 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 understand that I am not required to give my consent, and that while my refusal will not impact my health care providers' treatment of me, if I do not provide consent, Valeant will not be able to evaluate my eligibility for the Valeant PAP.** I understand that the information I provide may be subjected to re-disclosure and will no longer be protected by HIPAA. I understand that Valeant and any third party engaged to assist in the administration of the program has the right to verify my eligibility, including the right to audit any information provided by me or my physician. I understand that the parties disclosing or receiving my data pursuant to this authorization may receive financial remuneration from Valeant. I also understand that Valeant has the right to contact me directly by phone, mail, or email, if my email address was supplied on page 1, and to confirm product delivery and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation in the Valeant PAP at any time by either calling the Valeant PAP at **833-862-VPAP (833-862-8727)** or mailing a letter to **Valeant Patient Assistance Program, P.O. Box 429303, Cincinnati, OH 45242-9303.**

By signing below, I verify that the information I provide in this application, including all copies of documentation, if applicable, is complete and accurate, and that I am authorized to sign this application. I also verify that I am not currently receiving benefits or coverage for the product(s) selected on page 3 from Medicaid, Medicare, or any other public or private insurance or assistance program. I acknowledge and agree that I shall not report or count the value of any product provided to me under the Valeant PAP toward any insurance deductible or, if I am enrolled in Medicare Part D, as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit. In addition, I will not seek reimbursement from any insurance provider or plan, including any Medicare Part B or Medicare Part D plan, for the cost of any free product provided by the Valeant PAP and for the remainder of my eligibility period I will continue to receive all of my prescriptions for the selected products from the Valeant PAP. I also agree that I will contact Valeant if any of the information regarding my prescription drug coverage or insurance changes. I understand that this form expires in one year or when my program eligibility expires.

Patient or Authorized Representative Signature _____

Name (print) _____ Date _____

4 Alternate/Authorized Patient Representative (If Applicable)

Complete if Valeant PAP may address insurance or financial questions or other application-related issues with an Authorized Representative on your behalf.

Patient's Signature _____ **Date** _____

Authorized Patient Representative Name _____

Relationship to patient _____ Primary Phone # _____

Email _____

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To be completed by the Prescriber

Patient Name _____

Does the patient have any known allergies (required)? None ☐ Known _____

Please list the names of other medications the patient is currently taking

None ☐ Medications _____

1 Product Information

Select from product listing below and attach original valid prescription(s) with physician signature

Eligible patients may be able to receive product through this program for up to one year, as long as a valid prescription remains on file. **This is not a prescription.**

SHIP TO (required) ☐ Patient's Home ☐ Prescribing Physician's Office

NOTE: Orders for Controlled Substances and products administered by the physician will be shipped to comply with all state rules and regulations pertaining to how these items can be transported.

	Bausch + Lomb Products
☐	**ALREX®** (loteprednol etabonate ophthalmic suspension) 0.2%
☐	**BEPREVE®** (bepotastine besilate ophthalmic solution) 1.5%
☐	**BESIVANCE®** (besifloxacin ophthalmic suspension) 0.6%
☐	**LACRISERT®** (hydroxypropyl cellulose ophthalmic insert)
☐	**LOTEMAX®** (loteprednol etabonate ophthalmic gel) 0.5%
☐	**MACUGEN®** (pegaptanib sodium injection) intravitreal injection
☐	**PROLENSA®** (bromfenac ophthalmic solution) 0.07%
☐	**RETISERT®** (fluocinolone acetonide intravitreal implant) 0.59 mg for intravitreal use
☐	**TIMOPTIC®** in OCUDOSE® (timolol maleate ophthalmic solution) ☐0.25% ☐0.5%
☐	**VISUDYNE®** (verteporfin for injection), for intravenous use
☐	**VYZULTA™** (latanoprostene bunod ophthalmic solution) 0.024%
☐	**ZIRGAN®** (ganiciclovir ophthalmic gel) 0.15%
☐	**ZYLET®** (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension)

	Ortho Dermatologics Products
☐	**ACANYA®** (clindamycin phosphate and benzoyl peroxide) Gel, 1.2%/2.5%, for topical use
☐	**CARAC®** (fluorouracil cream) **Cream**, 0.5%
☐	**CLINDAGEL®** (clindamycin phosphate gel) topical gel, 1%
☐	**ELIDEL®** (pimecrolimus) Cream, 1% for topical use
☐	**JUBLIA®** (efinaconazole) topical solution, 10% ☐4 mL ☐8 mL
☐	**LOCOID®** (hydrocortisone butyrate) Lotion, 0.1%, for topical use
☐	**LUZU®** (luliconazole) Cream, 1% for topical use
☐	**NORITATE®** (metronidazole cream) Cream, 1% for topical use only
☐	**ONEXTON®** (clindamycin phosphate and benzoyl peroxide) Gel, 1.2%/3.75% for topical use
☐	**RENOVA®** (tretinoin cream) 0.02% for topical use, pump
☐	**RETIN-A MICRO®** (tretinoin) Gel microsphere for topical use ☐0.06% ☐0.08%
☐	**SOLODYN®** (minocycline HCl) extended release tablets for oral use ☐55 mg ☐80 mg ☐105 mg
☐	**ZYCLARA®** (imiquimod) **cream** 3.75%, for topical use ☐7.5 g pump ☐box of 28 packets

	Salix Pharmaceuticals Products
☐	**APRISO®** (mesalamine) extended-release capsules
☐	**CYCLOSET®** (bromocriptine mesylate tablets), for oral use
☐	**MOVIPREP®** (polyethylene glycol 3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate, and ascorbic acid for oral solution)
☐	**RELISTOR®** (methylnaltrexone bromide) tablets, for oral use, 90-count
☐	**RELISTOR®** (methylnaltrexone bromide) injection, for subcutaneous use (7 single-dose pre-filled syringes per carton) ☐8 mg/0.4 mL ☐12 mg/0.6 mL
☐	**UCERIS®** (budesonide) rectal foam
☐	**XIFAXAN®** (rifaximin) Tablets, for oral use, 550 mg

	Valeant Pharmaceuticals Products
☐	**ANCOBON®** (flucytosine) 500 mg Capsules
☐	**ANDROID®** (C-III) (methylTESTOSTERone Capsules, USP), 10 mg
☐	**CUPRIMINE®** (penicillamine) Capsules
☐	**DEMSER®** (metyrosine) Capsules
☐	**LODOSYN®** (carbidopa) tablets
☐	**MEPHYTON®** (phytonadione) Vitamin K_1 tablets
☐	**OXSORALEN-ULTRA®** Capsules (methoxsalen capsules, USP, 10 mg)
☐	**SYPRINE®** (trientine hydrochloride) capsules
☐	**TARGRETIN®** (bexarotene) capsules, for oral use
☐	**TARGRETIN®** (bexarotene) Gel 1%
☐	**TASMAR®** (tolcapone) Tablets
☐	**ZELAPAR®** (selegiline hydrochloride) Orally Disintegrating Tablets

☐	**Other** _____

Before prescribing any product on the above list, please see full Prescribing Information, including any Boxed Warning, Medication Guide, and/or Patient Information, available at ValeantPAP.com or call Valeant Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.

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To be completed by the Prescriber

Patient Name _____

2 Prescriber Information (*Required)

*First Name _____ *Last Name _____ *Designation _____

*Practice Name _____ Specialty _____

*Street Address _____

*City _____ *State _____ *ZIP Code _____

*NPI # _____ State License # _____ DEA # _____

Office Contact Name _____ Email _____

*Phone # _____ *Fax # _____

Business Hours (for deliveries) _____ ☐AM ☐PM to _____ ☐AM ☐PM

3 Shipping Information (Complete if shipping to prescriber's office and information is different from Prescriber Information)

Ship to Site/Facility Name _____ NPI # (if different from above) _____

Shipping Address _____

City _____ State _____ ZIP Code _____

Delivery Contact Name _____ Phone # _____

Business Hours (for deliveries) _____ ☐AM ☐PM to _____ ☐AM ☐PM

4 Prescriber Certification

I have determined, based on my independent clinical judgment, that the above-named patient should be treated with the Valeant product(s) identified on page 3. By signing below, I confirm that the patient is under my care on an outpatient basis; I will not charge the patient any fee for enrollment or other activities associated with the patient's participation in the Valeant PAP; I will not charge the patient for any professional services associated with the product(s) that are not covered by the patient's insurance provider or plan, or when the patient's costs associated with the prescribed product(s) represents a financial hardship and assistance has been approved by the Valeant PAP; I will not make any claim to any third party payer (e.g., Medicaid, Medicare, public or private insurance, etc.) for payment of product provided by the Valeant PAP; I will not sell, trade or return for credit the products(s) provided under the Valeant PAP; and I am not prohibited from participating in federally funded health care programs nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General. To the best of my knowledge, the patient does not have affordable third party insurance coverage for the selected product(s) through, for example, an HMO, private insurance, a State pharmacy program, Medicare, Medicaid, or Veterans Assistance, and the patient meets all other Valeant PAP eligibility requirements. By signing this form, I authorize Valeant PAP as my designated agent on behalf of the patient, to forward the prescription for the product(s) selected and presented herein by fax or other mode of delivery to the Valeant PAP dispensing pharmacy or distributor for fulfillment and/or dispensing. By including my email address on page 3, I agree to receive communication related to Valeant PAP by email.

Prescriber's Signature _____ **Date** _____

Physician's signature required. Stamped signatures are not allowed for controlled substances. **Special note:** New York prescribers must submit the patient's prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank, if applicable for your state. **Faxed prescriptions must be faxed from the prescriber's office.**

Valeant Patient Assistance Program benefits, rules, and product availability are subject to change at any time without prior notification.

You are encouraged to report negative side effects of prescription drugs to FDA at www.fda.gov/Safety/MedWatch, or call 1-800-FDA-1088.

Please see full Prescribing Information, including any Boxed Warning, Medication Guide and/or Patient Information, available at ValeantPAP.com or call Valeant Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.