

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





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



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.

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

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 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? \Box Yes \Box No
*Social Security or Green Card #		*U.S. Resident
Email		*Date of Birth
*Check Number of People in Household (inclue	de self) 🛛 1 🔲 2 🔲 3	B □ 4 □ 5 □ 6+ *Annual Household Income \$
2 Insurance Information (Select al	l that apply and, if appli	cable, 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 Me	dicare 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 rece	ived a denial letter for L	ow 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 Affa	irs (VA) Benefits? 🛛 Yes 🗋 No
State Elderly Drug Assistance? Yes No	o Other State/F	ederal Patient Assistance Program? 🛛 Yes 🗋 No
Plan Name		Phone #
Policy ID #	Rx BIN #	Rx PCN #

V1



To be completed by the Patient

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

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 _____

Alternate/Authorized Patient Representative (If Applicable)

Complete if Valeant PAP may address insurance or financial guestions 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		



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 _

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.

ALREX* (lotepreduct exploration beside ophthalmic suspension) 0.2% BEPREVE* (loopeatatine beside ophthalmic solution) 1.5% BESIVANCE* (besidioxacin ophthalmic suspension) 0.4% CVCLOSET* (formorphine mesylate tablets), for oral use DIAGESER** (loopeatatine beside ophthalmic suspension) 0.4% CVCLOSET* (formorphine mesylate tablets), for oral use, 90-count LOCENSER** (loopeatatine bacdum injection) intravireal injection RELISTOR* (methylanitexcone bromidel injection) intravireal injection) PROLENSA* (bromfenac ophthalmic solution) 0.07% RELISTOR* (methylanitexcone bromidel injection) intravireal injection) WISUDYNE* (information calcoling intravireal injection) RELISTOR* (methylanitexcone bromidel injection) WISUDYNE* (information calcoling intravireal injection) RELISTOR* (methylanitexcone bromidel injection) WISUDYNE* (information calcoling intravireal injection) RELISTOR* (methylanitexcone bromidel injection) WISUDYNE* (information for injection), for intravenous use Valeant Pharmaceuticals Products VIZULTA* (latanoprosteme bund ophthalmic solution) RELISTOR* (methylanite) SUSONNE* (informine capsules, USP), 10 mg ZURGAN* (ganicicolin ophthalmic solution) RELISTOR* ANCOBON* (flucytosine) 500 mg Capsules VIZULTA* (latanoprosteme bund ophthalmic solution) RELISTOR* ANCOBON* (flucytosine) 500 mg Capsules ZURGAN* (ganincicouri cream) Cream, 0.5% CA	Bausch + Lomb Products	Salix Pharmaceuticals Products
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Image: Display and the second seco		XIFAXAN® (rifaximin) Tablets, for oral use, 550 mg
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 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 LUZU® (luliconazole) 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 0.0.6% 0.0.8% SOLODYN® (minocycline HCl) extended release tablets for oral use 55 mg 80 mg 105 mg ZYCLARA® (imiguimod) cream 3.75%, for topical use 		SYPRINE® (trientine hydrochloride) capsules
 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 for oral use 555 mg 80 mg 105 mg ZYCLARA® (imiguimod) cream 3.75%, for topical use 		TARGRETIN® (bexarotene) capsules, for oral use
 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 HCI) extended release tablets for oral use 555 mg 80 mg 105 mg ZYCLARA® (imiquimod) cream 3.75%, for topical use 		TARGRETIN® (bexarotene) Gel 1%
 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 555 mg 80 mg 105 mg ZYCLARA® (imiquimod) cream 3.75%, for topical use 		TASMAR® (tolcapone) Tablets
 LUZO^o (fultionazole) 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 555 mg 80 mg 105 mg ZYCLARA[®] (imiquimod) cream 3.75%, for topical use 		ZELAPAR® (selegiline hydrochloride) Orally Disintegrating Tablets
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% 0.06% 0.08% SOLODYN® (minocycline HCl) extended release tablets for oral use SOLODYN® (minocycline HCl) extended release tablets for oral use ZYCLARA® (imiguimod) cream 3.75%, for topical use	 •	
Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use, pump Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use Image: L2%/3.75% for topical use		Other
RETIN-A MICRO® (tretinoin) Gel microsphere for topical use 0.06% 0.08% SOLODYN® (minocycline HCl) extended release tablets for oral use 55 mg 30 mg ZYCLARA® (imiquimod) cream 3.75%, for topical use		
Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use Image: SolodyN® (minocycline HCl) extended release tablets for oral use I	RENOVA® (tretinoin cream) 0.02% for topical use, pump	
Image: Space of the system Space of the system Image: Space of the system Space of the system <td< td=""><td></td><td></td></td<>		
ZYCLARA® (imiquimod) cream 3.75%, for topical use 7.5 g pump box of 28 packets	SOLODYN [®] (minocycline HCI) extended release tablets for oral use \Box 55 mg \Box 80 mg \Box 105 mg	
	ZYCLARA [®] (imiquimod) cream 3.75%, for topical use	

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. V1



To be completed by the Prescriber

Patient Name

City_

2 Prescriber Information	N (*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	🗆 АМ 🗆 Р	M	
3 Shipping Information (Complete if shipping to prescriber	's office and in	formation is different fr	om Prescriber Information)
Ship to Site/Facility Name		_ NPI # (if differ	ent from above)	
Shipping Address				

Delivery Contact Name		Phone #		
Business Hours (for deliveries)				

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 product(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 __

State _____ ZIP Code __

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.**

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

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