Bayer HealthCare Patient Assistance Program

Program Guidelines
&
Application Form

Please refer to the FDA Approved Patient Labeling enclosed in the product packaging for important safety information, including boxed warning.

Bayer HealthCare Patient Assistance Program
PO Box 29061
Phoenix, AZ 85038
Phone: 1-866-575-5002 Fax: 1-866-575-6568

PROGRAM GUIDELINES

The Bayer HealthCare Patient Assistance Program provides medication (listed below) for those in need, who have no prescription drug coverage and limited financial resources. All applications are reviewed on a case-by-case basis. Bayer reserves the right to make a separate, independent determination of patient eligibility and to modify or discontinue the Bayer HealthCare Patient Assistance Program, at any time, without notice.

Medication:

Adalat®cc (Nifedipine) 30mg
Adalat®cc (Nifedipine) 60mg
Adalat®cc (Nifedipine) 90mg
Angeliq® tablets (Drospirenone/Estradiol) 0.5 mg/1 mg/day
BETAPACE®(sotalol HCl) 80mg
BETAPACE®(sotalol HCl) 120mg
BETAPACE®(sotalol HCl) 160mg
BETAPACE AF®(sotalol HCl) 80mg
BETAPACE AF®(sotalol HCl) 120mg
BETAPACE AF®(sotalol HCl) 160mg
Biltricide® (praziquantel) 600mg
CIPRO® (ciprofloxacin) ORAL SUSPENSION 5%
CIPRO® (ciprofloxacin) ORAL SUSPENSION 10%
CIPRO® (ciprofloxacin hydrochloride) Tablets 250mg
CIPRO® (ciprofloxacin hydrochloride) Tablets 500mg
CLIMARA PRO®(estradiol/levonorgestrel transdermal system) 0.045/0.015mg/day
CLIMARA®(estradiol transdermal system) 0.025mg
CLIMARA®(estradiol transdermal system) 0.0375mg
CLIMARA®(estradiol transdermal system) 0.05mg
CLIMARA®(estradiol transdermal system) 0.06mg
CLIMARA®(estradiol transdermal system) 0.075mg
CLIMARA®(estradiol transdermal system) 0.1mg
Desonate® (desonide) Gel 0.05%
Finacea® (azelaic acid) Gel 15%
Menostar® (estradiol transdermal system) 14 mcg/day
Precose® (acarbose tablets) 25mg
Precose® (acarbose tablets) 50mg
Precose® (acarbose tablets) 100mg

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Eligibility:

To be accepted into the Bayer HealthCare Patient Assistance Program, a patient must reside in the United States, Puerto Rico, Guam or the US Virgin Islands.

Any patient who is enrolled in any **Government Prescription Programs (other than a Medicare Part D Prescription Drug Benefit plan) or Private Prescription Plans including, but not limited to Medicaid, State-sponsored Prescription Assistance programs, or has employee, military, retirement, or pension program drug coverage**, is not eligible for the Bayer HealthCare Patient Assistance Program.

If the patient receives prescription drug benefits from any of these types of programs or plans, then the Bayer HealthCare Patient Assistance Program cannot provide medication, even if the benefit program or plan does not cover the full cost of, or places limits on, medications. In the event that the patient does enroll in a Medicare Part D Prescription Drug Benefit Plan, the patient will still be eligible to receive free medication under the Bayer Patient Assistance Program for this calendar year. **Pharmacy discount cards or pharmaceutical assistance programs are not insurance coverage. You may still apply if you participate in these programs.

Application Process:

The patient should first seek any available state or government assistance (Medicare Part D, State Prescription programs, Veteran's Assistance, etc.) before applying to the Bayer HealthCare Patient Assistance Program. The patient may be asked to supply paperwork supporting the denial of assistance from the programs mentioned above.

The Application Process for the Bayer HealthCare Patient Assistance Program includes two elements:

- Completed application form by patient and healthcare provider
- Proof of Income

Once it has been determined that the patient may be eligible for the Bayer HealthCare Patient Assistance Program, the Application form must be completed by the Doctor/Prescriber and the patient and faxed to 1-866-575-6568, along with Proof of Income documentation (see below). The completed documents can also be mailed to:

Bayer HealthCare Patient Assistance Program
PO Box 29061
Phoenix, AZ 85038

Remember to keep a copy of all documentation for your records.

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Applications will be reviewed within 2 business days. Patients will be notified by mail if they have been approved or denied for assistance from the Bayer HealthCare Patient Assistance Program. Bayer HealthCare reserves the right to make all patient eligibility determinations.

- If approved, patient prescription request will be processed and mailed to address the complete address. (including suite number, if applicable)
- If denied, patient prescription request will be cancelled and patient a notification letter.

Proof of Income:

Include **copies** of the following when submitting your application:

1. Federal Tax Return (Form 1040/1040EZ) for the prior tax year (Please include all Tax schedules).

If no tax form was filed or does not represent current income, please provide all supporting documents which may include:

1. Wage and tax statements (W2) for both patient and spouse (if patient is married)
2. Social Security, Pension or Railroad Retirement statements (SSA-1099 or similar)
3. Statements of Interest, dividends or other income (1099-INT, 1099-DIV, 1099 or other forms)

Patient must report **all** income, including salary, pension, Social Security, etc. for patient and spouse. If the patient does not file an income tax return, they must provide a statement from the IRS stating that they do not file. If the patient has no source of income, please provide us with a letter of means of support (i.e. Food stamps, housing assistance, or any other assistance received).

The Bayer HealthCare Patient Assistance Program fax number is on the top of these forms. You may also mail in your completed application form and proof of Income documentation to:

Bayer HealthCare Patient Assistance Program
PO Box 29061
Phoenix, AZ 85038

Incomplete forms will delay processing time.

Shipping:

Once approved, the 3-month supply of medication will be shipped directly to the patient to the address supplied on the application form or to the HCP's office with complete address to include suite number. Patients will not be charged.

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Final Checklist before faxing or mailing in completed forms

☐ 1. Ensure application form is complete and signed before faxing or mailing in. Any information left blank may result in a delay of program approval.

☐ 2. Ensure proof of income meets the requirements listed above in the Program Guidelines section of this document

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APPLICATION FORM – Page 1 of 3

SECTION 1 – HEALTHCARE PROVIDER INFORMATION: (MEDICATION SHIPPED DIRECT TO PATIENT)

Date:_____ Patient Name:_____ Patient Date of Birth:_____

Prescriber's Name: _____ Physician NPI #: _____

Facility Name: _____ Office Contact Name and Extension: _____

Street Address: _____Suite/Apt #:_____

City: _____ State: _____ Zip: _____

Telephone: (____)_____ Fax: (____)_____

Select Box for Product Selection: (clearly select only one box)

	Adalat®cc (Nifedipine) 30mg
	Adalat®cc (Nifedipine) 60mg
	Adalat®cc (Nifedipine) 90mg
	Angeliq® tablets (Drospirenone/Estradiol) 0.5 mg/1 mg/day
	BETAPACE®(sotalol HCl) 80mg
	BETAPACE®(sotalol HCl) 120mg
	BETAPACE®(sotalol HCl) 160mg
	BETAPACE AF®(sotalol HCl) 80mg
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	Desonate® (desonide) Gel 0.05%
	Finacea® (azelaic acid) Gel 15%
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	Precose® (acarbose tablets) 25mg
	Precose® (acarbose tablets) 50mg
	Precose® (acarbose tablets) 100mg

Directions: _____ Refills: ☐ 3 ☐ 2 ☐ 1 ☐ 0

Quantity: 90 day Supply Quantity for Cipro, Biltricide, Desonate or Finacea: _____

Prescriber Signature: Date:

By signing, prescriber certifies that all information is correct and accurate, to the best of their knowledge, after a reasonable inquiry.

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SECTION 2 – PATIENT INFORMATION: (INCOME DOCUMENTATION MUST ACCOMPANY APPLICATION)

Patient Name (last, first): _____

Street Address or PO Box: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Home phone: (____)_____ Cell Phone: (____)_____

Social Security #:_____ Email: _____

Gender: ☐ Male ☐ Female

Allergy and Health Information

List any known drug allergies:_____ Check if none ☐

List any known health conditions:_____ Check if none ☐

Financial Information (if married, income from spouse must also be provided)

Marital Status: ☐ Single ☐ Married Other:_____

Current Gross Annual Household Income (including Social Security & Pension Benefits):_____

Number of household members dependent on income stated above (include applicant):_____

Eligibility Requirements

Do you reside in the United States, Puerto Rico, Guam or the US Virgin Islands? ☐ YES ☐ NO

Are you enrolled in any Government Prescription Coverage Programs? ☐ YES ☐ NO
(This includes Medicare Part D, Medicaid, Veteran's Administration and/or State or Local Programs

If you answered "yes", please provide name of program: _____

Are you enrolled in any Private Prescription Programs? ☐ YES ☐ NO
(This includes coverage through any private insurance, PPOs, HMOs)

If you answered "yes", please provide name of program: _____

Did you file a Federal Tax Return for the most recent year? ☐ YES ☐ NO

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SECTION 3 – PATIENT CONSENT AND AUTHORIZATION:

I may refuse to sign this authorization; however, if I refuse to sign I will not be able to participate in the Program. I certify that all of the above statements and proof-of-income information provided are correct. I certify that I am not enrolled in the Medicare Part D Prescription Drug benefit or any other government or private prescription drug plan. I understand that if I enroll in any other prescription drug program (other than a Medicare Part D Prescription Drug Benefit plan) or private prescription drug plan, I may no longer meet the eligibility requirements of the Bayer HealthCare Patient Assistance Program and will not be provided with free medication under it, even if the benefit program does not cover the full cost of, or places limits on, medications. I agree to notify the Bayer HealthCare Patient Assistance Program immediately if I become covered under the Medicare Part D Prescription Drug benefit, or any other government or private prescription drug plan. In the event that I do enroll in a Medicare Part D Prescription Drug Benefit plan, I understand that I am still eligible to receive free medication under the Bayer HealthCare Patient Assistance Program for this calendar year. I agree that I will not seek reimbursement from the Medicare Part D Prescription Drug Benefit plan or any other governmental program, whether state or federal, for any free product received under the Bayer HealthCare Patient Assistance Program. Furthermore, I understand that the cost or value of any product received from the Bayer HealthCare Patient Assistance Program will not be applied towards any required payments of True Out-of-Pocket expenses in connection with Medicare. I agree to provide the Bayer HealthCare Patient Assistance Program with documentation to verify that the information provided is correct, including bank statements, Federal Tax Returns, verification of non-filing for Federal Tax, W-2 forms, denial from insurance companies or state or government programs, etc.

I understand that Bayer may discontinue or modify the Bayer HealthCare Patient Assistance Program at any time, and without notice; although medication may be given to me without cost now, it does not mean that I will be entitled to receive it without cost indefinitely. I understand that the eligibility for enrollment in the Bayer HealthCare Patient Assistance Program is subject to Bayer's approval. No patient will be accepted into the program without the healthcare provider's and patient's (or legal representative's) original signature on this application. Bayer reserves the right to make a separate, independent determination of patient eligibility. **I agree to notify Bayer HealthCare Patient Assistance Program immediately of any changes that might affect my eligibility.**

This information is for the sole use of Bayer and/or its representative(s) to determine eligibility for assistance and administering the Bayer HealthCare Patient Assistance Program. Unless required by law, information will not be provided in an identifiable form to any other persons unless the patient agrees to the release in writing. This authorization will become effective when signed below and will remain in effect until revoked by the patient. A photocopy of this form is as valid as the original.

Patient's Name (PRINTED)

Patient or Legal Guardian (SIGNATURE) Date