SEBELA PHARMACEUTICALS INC.

Sebela Patient Assistance Program
Analpram HC Cream 1% and 2.5%

Sebela Patient Assistance Program
PO Box 219, Gloucester, MA 01931
Phone: 866-562-7902 Fax: 888-246-6527

Patient Instructions:

1. Complete all fields on page 1 and 2 of the application. Have your prescriber complete page 3 of the application. Incomplete applications will delay the processing of your application.
2. Sign the application.
3. Send the application and your prescription to the Sebela Patient Assistance Program.

YOUR INFORMATION

Name (First and Last): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Daytime Phone: _____

Social Security # or Green Card # (if applicable) _____ Date of Birth: _____

Email: _____
By providing your email you are giving us permission to contact you in this way.

Fax: _____
By providing your fax you are giving us permission to contact you in this way.

ELIGIBILITY INFORMATION

Residency Status: ___ U.S. Citizen ___Legal Resident ___Work Visa (attach a copy your work visa)

Gender: ___ Female ___ Male

My household income: _____

Required supporting documentation (select one):

- ☐ Applying before April 15 - copy of the first page of last year's tax return
- ☐ Applying after April 15 - copy of the first page of this year's tax return
- ☐ If on Social Security a copy of SSA 1099
- ☐ Copy of two most recent pay stubs for all employed household members
- ☐ Proof of all pensions, interest, alimony, child support and retirement payments for all household members
- ☐ If applicant has no income then a letter is required from applicant's healthcare provider, advocate or other person or agency attesting to zero income

My household size: _____

Check one:

- ☐ I have no health insurance coverage (private or government) that pays for Analpram HC Cream and have not been insured for at least three months
- ☐ I had health insurance coverage (private or government) that paid for Analpram HC Cream within the last three months but it expired. Date of expiration: _____ Insurer: _____
- ☐ I have no health insurance coverage (private or government) that pays for Analpram HC Cream but expect to have it within the next three months.

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Applicant's Name: _____ Date of Birth: _____

MEDICAL QUESTIONS

List all the medications you are currently taking, including over-the counter medicines (those you can buy without a prescription), supplements, natural remedies, etc. If you are taking no medications, then check this box: ☐ NONE.

_____
_____
_____
_____

List any allergies to medications you have. If you have no allergies, then check this box: ☐ NONE.

_____
_____
_____
_____

List any medical conditions you have, including any relative to this voucher.
If you have no medical conditions, then check this box: ☐ NONE.

_____
_____
_____
_____

THE AGREEMENT

You must sign the form before we can process your application and deliver your medication. I attest that the information in this application is true, complete and accurate. This authorization or a copy shall be valid for 6 months from the date of signature. I understand that the Sebela Patient Assistance Program reserves the right to request additional income verification or other information from me and may refuse my application based on any misuse, abuse or illegal distribution of any products in this program.

Applicant's Signature: _____ Date:_____

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Applicant's Name: _____ Date of Birth: _____

PRESCRIBER INSTRUCTIONS

Complete all fields on the application.

1. Sign the application.
2. Attach a prescription for Analpram HC Cream 1% or 2.5% for a one month supply (maximum one 1 oz. tube) with up to 2 refills. A new prescription must be submitted every three months.
3. Mail the application to: Sebela Patient Assistance Program, PO Box 219, Gloucester, MA 01931 or fax from your office fax to: 888-246-6527

PHYSICIAN INFORMATION

Prescriber's Name: _____ Facility/Practice: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____ Email: _____

DEA Number_____ NPI Number _____

By providing your email you are giving us permission to contact you in this way.

By providing your fax you are giving us permission to contact you in this way.

☐ Check box to have prescription sent to the physician's address listed above. Otherwise, the prescription will be sent to the patient's home address.

PATIENT INFORMATION

Please select one or more of the following diagnoses that justify the need for this medication:

☐ Hemorrhoids

☐ Other _____ ICD-10 _____

PRESCRIBER ATTESTATION

You must sign the form before we can process your patient's application and send the medication.

I attest that the information in this application is true, complete and accurate. This authorization or a copy shall be valid for 6 months from the date of signature. I understand that the Sebela Patient Assistance Program reserves the right to request additional information from me and may refuse my application based on any misuse, abuse or illegal distribution of any products in this program.

To the best of my knowledge, this patient is financially needy, has no insurance coverage for Analpram HC Cream and has a medical need for this medication.

Prescriber's Signature: _____ Date:_____