TEVA CARES FOUNDATION

6900 College Boulevard, Suite 1000 ◆ Overland Park, KS 66211
Phone: 877-237-4881 ◆ Fax: 877-438-4404

Thank you for your interest in the TEVA CARES FOUNDATION. The TEVA CARES FOUNDATION Patient Assistance Program provides prescription medicines at no cost to patients who qualify. If you have no prescription drug coverage and meet the income guidelines below, you may qualify for this program. Please complete and submit this application to see if you qualify. Each application will be considered on a case by case basis.

Income Guidelines for TEVA CARES FOUNDATION Patient Assistance Program

Number of people in your household	Total yearly income
1 person	$34,470
2 people	$46,530
3 people	$58,590
4 people	$70,650
5 people	$82,710

Patients: Please complete the following steps to apply for this program:

1. Complete the patient information section, the financial information section, the insurance information section and the product shipment information section.
2. Attach copies of proof of income (described on the next page).
3. Read the consent language and sign the application form.
4. Fax or mail the completed form and proof of income as described below.

Physicians: Please complete the following steps:

1. Complete the physician information section and the prescribing information section.
2. Read the consent language and sign the application form.
3. Fax or mail the completed form as described below.

Please fax the completed form and proof of income to **1-877-438-4404** or mail to:

TEVA CARES FOUNDATION
Patient Assistance Program
6900 College Boulevard, Ste. 1000
Overland Park, KS 66211

If you have any questions please call the program at **877-237-4881**. We are available to answer your call Monday through Friday, from 9:00am to 8:00pm Eastern Time (excluding holidays).

For Internal Use Only	Case #:		Date:	

TEVA CARES FOUNDATION APPLICATION FORM

6900 College Boulevard, Suite 1000 ◆ Overland Park, KS 66211
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PATIENT INFORMATION:

Patient Name (First MI Last): _____

Social Security #: _____ **Date of Birth:** _____

Mailing Address _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Contact Name (if other than patient): _____ **Contact Phone:** _____

Permanent US Resident? ❑ YES ❑ NO **Gender:** ❑ Male ❑ Female

FINANCIAL INFORMATION:

What is the **number of people in your household** (including you, your spouse and your dependents)?_____

What is the **total yearly income** for your household listed above? (Adjusted Gross Income) $_____

You must provide proof of income to apply for this program. Please provide a copy of your most recent Federal tax return; OR Social Security Income Yearly Benefits Statement. Please call 877-237-4881 for other documentation questions.

INSURANCE INFORMATION:

Do you have any insurance coverage? ❑ YES ❑ NO

For each policy you have, including any secondary coverage, please provide the following:

	Insurance Name:	Phone #:	ID / Policy #:
Primary:			
Secondary:			

**** Please provide copies of the front and back of all insurance cards (enlarged if possible)***

Do you have the following insurance coverage?

Employer provided or other private insurance	❑ YES ❑ NO
Medicare A or B **If yes**, list Effective Date:_____	❑ YES ❑ NO
Medicare Advantage	❑ YES ❑ NO
Medicare Part D	❑ YES ❑ NO
Medicaid	❑ YES ❑ NO
What is your Medicaid status? ❑ Not applied ❑ Denied ❑ Pending	
State Assistance Program	❑ YES ❑ NO
Veterans	❑ YES ❑ NO
Are you a Veteran?	❑ YES ❑ NO
If yes, have you applied for VA benefits?	❑ YES ❑ NO
Other insurance	❑ YES ❑ NO

CONSENT:

I promise that the information provided in this application is current, complete, and accurate. I agree to notify the TEVA CARES FOUNDATION (THE FOUNDATION) as soon as possible if my employment or insurance status changes. I agree that my doctors, pharmacists, insurance companies, employers, the THE FOUNDATION and their agents and others may share all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my enrollment or participation in the TEVA CARES FOUNDATION Patient Assistance Program. I give THE FOUNDATION and their agents permission to contact me in connection with this program. I understand that completing this application does not guarantee acceptance into the Program. I understand that the THE FOUNDATION reserves the right to modify or discontinue this Program at any time without prior notice and reserves the right to recall the product when necessary. I promise that I have not received, and will not seek to receive, insurance reimbursement for any drug I request or receive as part of the TEVA CARES FOUNDATION Patient Assistance Program. I understand that I can withdraw from the Program at any time by notifying THE FOUNDATION in writing at the address above. I agree that a photocopy or faxed copy of this consent may be used in place of the original.

➔ Patient/Legal Guardian* Signature:_____ Date:_____

** Please provide a description of the Legal Guardian's authority to act for the patient.*

For Internal Use Only	*Case #:*		*Date:*		*Patient Name:*	

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PHYSICIAN INFORMATION:

Physician Name: _____ **DEA #:** _____
NPI #: _____ **Medical License #:** _____
Facility Name: _____ **Tax ID:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Medicaid Provider # & Pin: _____ **BCBS Provider #:** _____
Clinic Contact: _____ **Contact Title:** _____
Contact Phone: _____ **Ext:** _____ **Contact Fax:** _____

PRESCRIBING INFORMATION FOR PATIENT: _____

Health Conditions: _____
Medication Allergies: _____
Medications Currently Taking: _____

If shipping address is the same as the mailing address, please confirm by checking the box below.
☐ **Mailing Address Is Same As Shipping Address (PO Boxes are not allowed)**
If not, please indicate shipping address below. ☐ **Ship to Patient** ☐ **Ship to Office**

Shipping Address: _____
City: _____ State: _____ Zip: _____

Medications Available: **Cyclosporine Capsules Modified, Cyclosporine Oral Solution Modified, GABITRIL®, GALZIN®, GRANIX™, NUVIGIL®, ORAP®, ProAir HFA®, Proglycem®, QNASL™, QVAR®**

Product Requested:	**Strength:**	**Quantity:**		
			☒ **90 day supply**	**Refills:** ☐ **None** ☐ **1 Year**
Frequency/Directions:				
☐ **FENTORA®**			☒ **28 day supply**	**Refills:** ☐ **None** ☐ **1 Year**
☐ **TEV-TROPIN®**			☒ **30 day supply**	**Refills:** ☐ **None** ☐ **1 Year**
Frequency/Directions:				

☐ **DILUENT SYRINGE - BD LL 3ML/21G** **QUANTITY FOR 30 DAY SUPPLY:** _____
☐ **INJECTION SYRINGES - BD ULTRA FINE:** ☐ **.3ML/31G** ☐ **.5ML/30G** ☐ **1ML/31G** **QUANTITY:** _____
☐ **ALCOHOL SWABS (100 ct)** ☐ **SHARPS CONTAINER**
☐ **INJECT-EASE®** ☐ **TJET™ INJECTION DEVICE** ☐ **NEEDLE FREE HEADS** ☐ **VIAL ADAPTOR**
Refills for Tev-Tropin Supplies: ☐ **None** ☐ **1 Year**

On behalf of my patient, I request assistance for the drug specified in this application. I attest that the information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed the drug specified in this application based on my professional judgment of medical necessity. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested and/or supplied under the Program. I certify that no free product provided under this Program will be distributed for sale or returned for credit. I understand that the TEVA CARES FOUNDATION reserves the right to modify or terminate this Program at any time without prior notice and reserves the right to recall the product when necessary. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug.

Provider Signature: _____ **Date:** _____