

**HEALTHCARE PROVIDER INFORMATION**

DEA Number: \_\_\_\_\_ Physician Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**MEDICATION INFORMATION – Please complete Prescription/Order Form on second page**

Requested product:  AndroGel®  ACEON®  CREON®  PROMETRIUM®

*The product listed above must be shipped to the patient's address*

*The products listed above may be shipped to either:*  
Licensed Prescriber's Office  Patient's Address

**Patient diagnosis (ICD.9 code) :**

My signature below certifies that the person named on this form is my patient and medications received from Solvay for patient assistance are only for the use of this patient's medical treatment in which I will be supervising. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor returned for credit. By signing, I also agree that Solvay has the right to contact my patient directly to confirm receipt of medications, and to revise, change, or terminate this program at any time. To the best of my knowledge, my patient meets Solvay's criteria for this program. The enclosed application must be filled out completely and signed by a licensed practitioner (an MD or DO, or a Nurse Practitioner or Physician Assistant in those states where NPs and PAs are authorized to write prescriptions).

Signature of Physician: \_\_\_\_\_ Date \_\_\_\_\_  
X

**PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line.**

Social Security / ID No: \_\_\_\_\_ Patient Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ US Resident:  Yes  No Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Veteran:  Yes  No Disabled:  Yes  No Patient Language:  English  Spanish  Other: \_\_\_\_\_

Is this patient an in-patient or out-patient?:  In-patient  Out-patient If an in-patient, please explain: \_\_\_\_\_

**FINANCIAL INFORMATION – Please attach a copy of household's most recent year tax return (1040, 1040EZ, 1099, etc.)**

Total # of people in household (include self): \_\_\_\_\_ Total Assets per Household: \_\_\_\_\_  
Includes bank account, IRA, annuity, stocks, bonds, etc.

LIST ALL SOURCES OF GROSS MONTHLY AMOUNTS PER HOUSEHOLD			
Salary/Wages (All Sources)	\$	Disability	\$
Pension/Retirement	\$	Alimony/Child Support	\$
Social Security	\$	Unemployment Compensation	\$

ATTACH PROOF OF INCOME

Total Gross Monthly Household Income: \_\_\_\_\_

**INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)**

	Medical Coverage (circle one)	Prescription Drug Coverage for Requested Product (circle one)	Eligibility Status E=Eligible P=Pending I=Ineligible (reason)	Policy Number	Phone Number	Contact Person
Medicare	Y N	Y N			( )	
Medicare Part D	Y N	Y N			( )	
Medicaid	Y N	Y N			( )	
Private Insurance	Y N	Y N			( )	
State Elderly Drug Assistance	Y N	Y N			( )	
State Children Health Insurance	Y N	Y N			( )	
Veterans Assistance	Y N	Y N			( )	
Other:	Y N	Y N			( )	

**APPLICANT DECLARATION**

I attest that the information included in this application is correct and complete. I understand that the information on this enrollment form and my prescription for this product will only be used for purposes of determining eligibility and administering the Solvay Patient Assistant Program. I further understand that documentation is requested to verify financial or insurance information. I understand that assistance in the form of free drug is contingent upon my ability to meet the program eligibility criteria, and Solvay Pharmaceuticals reserves the right, at any time without notice to modify or discontinue this program and its eligibility criteria. I authorize the Solvay Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources, as deemed necessary, to ensure the accuracy and completeness of this application and to provide services through this program.

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
X

# Prescription and Order Form

Section 1 - Physician and Prescription Information				
Physician Name:		DEA/State License #:	Phone: ( )	Fax: ( )
Address: (no P.O. Box)		City:		State: Zip:
Prescription	Instructions	Quantity	Day Supply	Refills
<b>AndroGel® 1% Topical</b> (maximum daily dose 10 gms) Strength: <input type="checkbox"/> 2.5gm <input type="checkbox"/> 5 gm	<input type="checkbox"/> 30 packets per box <input type="checkbox"/> 2x75gm pump (1 metered dose is 1.25gm)		<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	
<i>Enclose a copy of a government issued ID when ordering the product listed above: Driver License, State ID, Military ID, etc.,                      The products listed above must be shipped to the patient's address</i>				
<b>Physician Signature:</b> (must be MD / DO no PAC / NP) _____ /____/____ (substitution allowed) (dispense as written) (date)				
<i>The products listed below may be shipped to patient's address or healthcare provider's office;                      if not indicated medications will be shipped to patient's address.</i>				
Medication should be sent to: Licensed Prescriber's Office <input type="checkbox"/> Patient's Address <input type="checkbox"/>				
Product Requested	Instructions	Quantity	Bottles Req.	Refills
<b>ACEON® (perindopril erbumine) Tablets</b> <input type="checkbox"/> 2MG <input type="checkbox"/> 4MG <input type="checkbox"/> 8MG			<input type="checkbox"/> 100	
<b>CREON® (pancrelipase) Delayed-Release Capsules</b> <input type="checkbox"/> 6,000 Lipase Units <input type="checkbox"/> 12,000 Lipase Units <input type="checkbox"/> 24,000 Lipase Units			<input type="checkbox"/> 100	
<b>PROMETRIUM® (progesterone, USP)</b> <input type="checkbox"/> 100MG <input type="checkbox"/> 200MG			<input type="checkbox"/> 100	
<b>Physician Signature:</b> _____ /____/____ (substitution allowed) (dispense as written) (date)				
Section 2 - Patient Information				
Patient Name:		SS #, Green Card, VISA:		
Street Address:		Date of Birth:		
City:	State:	Zip:	Phone: ( )	
Medication Information				
Patient allergies: <input type="checkbox"/> No Known _____				
Please list the names of other medications the patient is currently taking: <input type="checkbox"/> None _____				

**Please fax this form to 1-800-276-9901 or mail to address above  
 If you are a New York Prescriber, please use an original New York State Prescription Form.**