Important Steps for Patient and Physician/Prescriber:

1. Complete ALL information on the application form.

2. Take the completed application to your physician/prescriber. **Both the physician/ prescriber and the patient MUST sign the application.**

3. Have your physician/prescriber write your prescription(s) in Section 2 of the application.
   - A single application may include prescriptions for up to **3** medicines.
   - Each prescription may not exceed a 90-day supply at a time, with a maximum of **3 refills** and prescriber must document days supply needed.
   - Each application, if approved, is valid until the end of the calendar year.
   - A separate Akorn Patient Assistance Program application is **REQUIRED** for each patient.

4. Prescriber to fax **completed** applications to: **Akorn Patient Assistance Program**
   1-844-500-5254

Please Note

- Incomplete or incorrectly completed applications will be returned.
- **Section 2 is your prescription. There is no need to write your prescription** on a separate prescription form unless prescriber resides in New York.
- Patient's prescription will be sent to the patient's home address unless otherwise requested by the patient/prescriber in Section 1 of the application.
- For additional applications or assistance, please call 1-844-202-5909.

Patient Assistance Program Application

NOTE TO PHYSICIAN: A SEPARATE APPLICATION FORM IS REQUIRED FOR EACH PATIENT.
SECTION 1: COMPLETE THE PATIENT INFORMATION BELOW . PLEASE PRINT (USE BLACK BALLPOINT PEN).

Patient's First Name _____ M.I. _____

Last Name _____

Address _____ Apt. No. _____

City _____ State _____ ZIP _____

Phone _____ Date of Birth _____ _____ _____ Gender: Male Female
MM DD YY

Your Social Security No. _____ I Don't Have a Social Security No. ❑

No. of Household Members (including patient) _____

List current **annual** household income below. Indicate the source(s) of your income by checking all boxes that apply.

Total Annual Income: $

Social Security Benefits (SS, SSI, SSDI)❑ Wages❑

Interest/Dividends❑ Pension❑ Unemployment Compensation❑

Please list other source(s) _____

_____

Do you have prescription coverage? YES❑ NO❑

If yes, please check all boxes that apply.

Medicare❑ Medicaid❑ State❑ Pharmacy❑ Employer❑

Other (private policy or Medicare Supplement)❑

If other, please complete. _____

Insurance Carrier _____

Policy ID _____ Group No. _____

APPLICANT DECLARATIONS AND AUTHORIZATION

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for this program. I certify that I cannot afford this medication. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that Akorn Patient Assistance Program, Inc. (Akorn PAP) reserves I authorize Akorn PAP and its affiliates to forward this prescription to a dispensing pharmacy on my behalf. Akorn PAP is not acting as a dispensing pharmacy. Akorn PAP is not responsible for verifying any information contained in Section 2, including without limitation allergies, medical conditions, or other medications being taken by me. With respect to this application, I understand that only the dispensing pharmacy will be responsible for the information contained in Section 2 of this application form.

Patient's Original Signature _____ **Date** _____

APPLICANT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that in order for the Akorn Patient Assistance Program, Inc. (Akorn PAP) to provide me with assistance, it will need to obtain, review, use, and disclose my personal health information (PHI), including information relating to my medical condition and information on my application form. I authorize my physician, pharmacy, and my health plan(s) to disclose my PHI to Akorn PAP and its administrators as necessary to complete the Akorn PAP application process or to verify my application. I understand that my name, address, and any other personal identifying information provided in my application will be available to Akorn PAP and its affiliates. I understand that my PHI disclosed under this application may no longer be protected by privacy laws and may be re-disclosed by Akorn PAP only for the purposes described here. I understand that I if I don't provide this Authorization, I won't be able to obtain assistance from Akorn PAP. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician and Akorn PAP, and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization. If I do not cancel this Authorization, the Authorization will expire 15 months from the date signed below. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient's Original Signature _____ **Date** _____

Ship Product to: Patient's Home❑ Physician's Office❑

Physician must complete Sections 2 and 3 on the back of this form.

Patient Assistance Program Application

SECTION 2: THIS IS THE PRESCRIPTION. PHYSICIAN/PRESCRIBER MUST COMPLETE THE PRESCRIPTION AND PRODUCT INFORMATION BELOW. PLEASE PRINT.

NY PRESCRIBERS – **Please submit prescription on an original NY State prescription blank.**

Patient's First Name _____ M.I. _____

Last Name _____

Date of Birth _____ _____ _____
MM DD YY

Betimol 0.25% ❑	Days Supply _____	Directions _____	Refill ____ (1, 2, or 3) Times
Betimol 0.5% ❑	Days Supply _____	Directions _____	Refill ____ (1, 2, or 3) Times
Zioptan 0.0015% ❑	Days Supply _____	Directions _____	Refill ____ (1, 2, or 3) Times

Physician/Prescriber State License Number _____ **Date** _____

❑ **Dispense As Written: Physician/Prescriber's Signature** _____ **(We cannot accept signature stamps.)**

ALLERGIES ❑ None ❑ Other _____

CURRENT MEDICATION(S) BEING TAKEN BY PATIENT: _____

SECTION 3: COMPLETE THE PHYSCIAN/PRESCRIBER INFORMATION BELOW AND SIGN THE FOLLOWING STATEMENT.

Physician's First Name _____ M.I. _____

Last Name _____

Professional Designation _____

Site _____

Address (no PO Box No.) _____

Bldg/Suite _____

City _____ State _____ Zip _____

Phone _____ Ext. _____

Secure Fax _____

PHYSICIAN/PRESCRIBER ATTESTATION

I certify that this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize the Akron PAP, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

Physician/Prescriber's Original Signature (we cannot accept signature stamps)

_____ **Date** _____

FAX COMPLETED APPLICATIONS TO 1-844-500-5254