ENDO PHARMACEUTICALS

Mail the application, financial documentation, copy of federal or state ID, and prescription to:
Endo Patient Assistance Program
P.O. Box 66761
St. Louis, MO 63166-6761

Questions – Please call 1-866-824-4747

IMPORTANT - PLEASE COMPLETE THIS APPLICATION AND FOLLOW THE INSTRUCTIONS BELOW :

1. **Enclose a valid prescription (not to exceed 30 day supply).**
2. **Attach copy of a federal or state ID.**
3. **Attach Proof of Income (Examples include IRS Form 1040, 1040EZ, 1040X, 8453, 8879, 4506T, 1099, 1099R, 1099RR, social security or disability statement, etc.)**

Section 1 - Physician Information

Physician Name	DEA	Phone: ( ) Fax: ( )	
Address:	City:	State:	Zip:

Physician/Prescriber Attestation: To the best of my knowledge, this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my patient's home, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature (original signature):	Date:

Section 2 - Patient Information

Patient Name:			SS#: - -
Street Address (No P.O. Box):		Date of Birth: / /	Male ☐ Female ☐
City	State	Zip	Phone ( )
Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 other	U.S. Resident? Yes ☐ No ☐	Are you a Veteran of the US Armed Forces? Yes ☐ No ☐	Are you Disabled? Yes ☐ No ☐

Allergies: ☐ Yes ☐ No If Yes, please list:

Current Medications Taking:

Current Medical Conditions:

Financial Information Note: Please attach Proof of Income (Examples include IRS Form 1040, 1040EZ, 1040X, 8453, 8879, 4506T, 1099, 1099R, 1099RR, social security or disability statement, etc.)

List All Sources, Gross Monthly Amounts

Salary/Wages $_____ Social Security $_____ Alimony/Child Support $_____

Disability $_____ Pension/ Retirement $_____ Unemployment/ Workers Comp $_____

Total Gross Household Monthly Income: $_____

Total Patient Assets: $_____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Insurance Information	Check one	Insurance Information	Check one
Private Prescription Drug Coverage	☐Yes ☐No	Medicaid – If Yes, do you have QMB coverage?	☐Yes ☐No ☐Yes ☐No
Medicare	☐Yes ☐No		

I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I authorize any Health Care Provider, Employer, Person or Organization to release any information regarding the medical, mental, alcohol or drug abuse history, or treatment to any other party necessary for the purpose of administration of the patient assistance program. I understand that the Endo PAP reserves the right to refuse to enroll me or disenroll me from the patient assistance program based on any unintended use, abuse or illegal distribution of any products in this program. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this Application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. Endo, Inc. is not responsible for verifying any of the information contained in Section 2 above, including medical conditions, allergies, or other medications that I am taking. This authorization or a copy shall be valid for 12 months from the date of signature.

Patient's Signature (original signature):	Date: