CEPHALONCARES FOUNDATION

6900 College Boulevard, Suite 1000 ◆ Overland Park, KS 66211
Phone: 877-CEPH881 (877-237-4881) ◆ Fax: 877-438-4404

FAX

TO:	**FROM:**
FAX:	**PAGE(S):**
RE:	**DATE:**
CASE:	**PRODUCT:**

Thank you for your interest in the CEPHALONCARES FOUNDATION. The CEPHALONCARES 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 CEPHALONCARES FOUNDATION Patient Assistance Program

Number of people in your household	Total yearly income
1 person	$32,490
2 people	$43,710
3 people	$54,930
4 people	$66,150
5 people	$77,370

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/voucher 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:

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

If you have any questions please call the program at **877-CEPH881 (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:	

CEPHALONCARES 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:** _____

Street Address: _____ **Phone:** _____

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

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

US Citizen/Legal 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 you, your spouse and your dependents?

$_____

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

If you have questions or do not have copies of these documents please call **877-CEPH881 (877-237-4881).**

INSURANCE INFORMATION:

Do you have any insurance coverage for prescription drugs? ❑ 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 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

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PRODUCT/VOUCHER SHIPMENT INFORMATION:

If you are eligible and are enrolled in the program, your prescription medication or a voucher for your prescription medication (that you will need to take to the pharmacy along with a valid prescription) will be mailed to you.

If your shipping address is the same as your mailing address, please check the box below. If not, please provide your physical shipping address below.

❑ Shipping Address Is Same As Mailing Address ***(PO Box numbers are not allowed)***

Shipping Address: _____

City: _____ State: _____ Zip: _____

CONSENT:

I promise that the information provided in this application is current, complete, and accurate. I agree to notify the CEPHALONCARES FOUNDATION as soon as possible if my employment or insurance status changes.

I agree that my doctors, pharmacists, insurance companies, employers, the CEPHALONCARES 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 CEPHALONCARES FOUNDATION Patient Assistance Program.

I give the CEPHALONCARES 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 CEPHALONCARES 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 CEPHALONCARES FOUNDATION Patient Assistance Program.

I understand that I can withdraw from the Program at any time by notifying the CEPHALONCARES 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:_____

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

Date:_____

For Internal Use Only	Patient:		Date:		Case:

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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:

Product Requested:	Dose:	Frequency:		
☐ **FENTORA®**			☒ **30 day supply**	(Voucher Process)
☐ **GABITRIL®**			☒ **90 day supply**	(Product shipped to patient)
☐ **NUVIGIL®**			☒ **90 day supply**	(Product shipped to patient)
☐ **PROVIGIL®**			☒ **90 day supply**	(Product shipped to patient)

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 CEPHALONCARES 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.

Physician Signature:_____ Date:_____