Application

The *KingKare*® Patient Assistance Program℠ (KingKare) provides certain *King Pharmaceuticals*® prescription drugs free of charge to qualifying U.S. residents needing temporary assistance. Before applying for the program, please read the following instructions and eligibility requirements.

KingKare®
King Pharmaceuticals, Inc. Patient Assistance Program℠

P.O. Box 608 | Somerville, NJ 08876

Call 866-734-7366 with questions.

Instructions

- ☐ Patient and practitioner sections must be filled out completely.
- ☐ **Attach a photocopy of the most recent federal tax return(s) for the patient's head of household**. If no one in the patient's household files a tax return, please attach other proof of annual income.
- ☐ **Attach an original prescription for a multiple of the package sizes specified** in the chart below of the KingKare brand name product(s) you are requesting (approximately a 90-day supply).
- ☐ Mail application, prescription and photocopy of federal income tax return to the following address:

KingKare Patient Assistance Program
P.O. Box 608
Somerville, NJ 08876

- ☐ Please allow 3 weeks for processing and delivery of the medication to the ***practitioner's office*** for approved patients.
- ☐ Both the patient and practitioner will be advised in writing of any denied requests.
- ☐ All incomplete applications will be sent to either the patient or practitioner for completion.

Program Eligibility

- ☐ Patient must be a legal resident of the United States.
- ☐ Patient cannot have or qualify for any government prescription drug coverage such as Medicaid, Veteran's Administration, or any state or local programs.
- ☐ Patient cannot have Medicare Part D prescription drug coverage. (If the patient is eligible for Medicare Part D, the patient should be encouraged to enroll.)
- ☐ Patient cannot have any private prescription drug coverage.
- ☐ Patient's total annual household income must be ***at or below*** the income levels listed below (see chart).

Household Size	Total Annual Household Income	Total Monthly Household Income
1	$21,660	$1,805
2	$29,140	$2,428
3	$36,620	$3,051
4	$44,100	$3,675
5	$51,580	$4,298
6	$59,060	$4,921
7	$66,540	$5,545
8+	$74,020	$6,168

Please Note: While KingKare will make every effort to grant aid when needed, this program is limited to available resources and may be discontinued or revised at any time.

Products

The following products are available in the strengths indicated to patients enrolled in the KingKare program.

Product	Strength(s)	Unit Size
Levoxyl® (levothyroxine sodium)	25, 50, 75, 88, 100, 112, 125, 137, 150, 175 and 200 mcg	100-tablet bottle
Skelaxin® (metaxalone)	800 mg	100-tablet bottle

For your convenience, you may request product re-orders 60 days after your most recent order by sending in a new, completed application and prescription. It is not necessary to provide proof of income with each application during a single 12-month period unless there is a change in circumstance.

Application

Photocopy for additional forms

KingKare®
King Pharmaceuticals, Inc. Patient Assistance Program℠

Patient Section* The patient or patient's legal guardian must complete this section.

Name

Address

City **State** **Zip Code**

Date of Birth **Sex** M ☐ or F ☐ **Phone Number**

Is the patient a legal U.S. resident? **Yes** ☐ **No** ☐ **Social Security / Green Card / Visa #**

Does the patient have or qualify for prescription drug coverage in any government programs? **Yes** ☐ **No** ☐
(This includes Medicaid, Veteran's Administration and any other state or local programs.)

Does the patient have Medicare Part D prescription drug coverage? **Yes** ☐ **No** ☐

Does the patient have prescription drug coverage in any private programs? **Yes** ☐ **No** ☐
(This includes coverage through any private insurance, HMOs, or PPOs.)

What is the total *annual household* income including Social Security & pension benefits? **$**
(annual)

How many residents are there in your household? (check box) **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+** ☐

Patient Certification and Authorization
I verify that the information provided in this application is complete and accurate. I certify that I have no government or private prescription drug insurance coverage and do not have financial resources to pay for the prescribed therapy. I understand that KingKare reserves the right at any time and without notice to modify the eligibility criteria or discontinue the program. I understand that I am expected to seek any available state or government assistance before reapplying to the KingKare Patient Assistance Program. I authorize KingKare to use the information on this application to process and verify my request for medication and for record keeping.

Signature of Patient or Legal Guardian **Date**

Licensed Practitioner Section* The licensed practitioner must complete this section.

Name **Professional Designation** (MD, DO, etc.)

Office Address (no P.O. boxes)

City **State** **Zip Code**

DEA # (If you do not have a DEA #, ***attach*** a copy of your state license)

Contact Person in Office **Office Phone #**

Office Fax #

Practitioner Certification and Agreement
I represent that, to the best of my knowledge, the information contained in this application is complete and accurate, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and has insufficient financial resources to pay for the prescribed therapy. I understand that KingKare reserves the right to modify or terminate this program at any time. My signature certifies that goods received from KingKare are for the use of the above-named patient only and that they will not be resold nor offered for sale, trade or barter and will not be returned for credit. I agree not to charge the patient or any third party for the pharmaceuticals received from KingKare. I have obtained any authorization or consents from the patient required under applicable state or federal law to submit this application.

Original Signature of Licensed Practitioner
(no stamped signatures) **Date**

**If all information is not clearly and completely filled out, this form will not be processed.*

☐ **Attach a prescription for a multiple of the package size indicated** in the attached schedule.

☐ **Attach the most recent federal tax return for the patient's head of household** or other proof of income.

☐ **A new application and prescription must be sent in to receive a re-order**. Proof of income is only necessary every twelve months.

RETURN COMPLETED APPLICATION TO: KingKare Patient Assistance Program | P.O. Box 608 | Somerville, NJ 08876 | 866-734-7366