Bayer HealthCare Pharmaceuticals

Patient Assistance Program
CIPRO® ORAL SUSPENSION Annual Patient Enrollment
6 West Belt, W66
Wayne, NJ 07470-6806
Phone: 1-866-575-5002
Fax: 1-866-575-6568

SECTION 1 – HEALTHCARE PROVIDER INFORMATION: (MEDICATION SHIPPED TO PRESCRIBER ONLY)

Prescriber's Name _____ **PLEASE CIRCLE** MD, DO, PA-C, ARNP, OTHER **(IF OTHER, PLEASE PROVIDE)** _____

State License # _____ Exp. Date: _____ DEA #: _____

Practice Name: _____

Street Address: _____

Suite #: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Office Contact Name, Title and Extension: _____

Telephone: (___)_____ Fax: (___)_____ Email: _____

Product	Strength (Please Circle)		# of Bottles	Dosage Schedule
CIPRO® (ciprofloxacin) **ORAL SUSPENSION**	**5%**	**10%**		

In addition to indicating the prescription above, please attach a written prescription

I represent that the information contained in this application is complete and accurate **to the best of my knowledge.** I certify that the patient identified on this application will be given **Cipro®** free of charge provided by the Bayer Patient Assistance Program. No third party, governmental program or patient will be charged for the free product, and no free product will be sold, traded or distributed for sale**. I agree to notify the Bayer Patient Assistance Program immediately if my patient elects to be covered under the Medicare Part D Prescription Drug benefit, or any other government or private prescription drug plan**.

_____ _____
Authorized Doctor/Prescriber's Signature (Stamps are not accepted) **Date**

SECTION 2 – PATIENT INFORMATION: **(INCOME DOCUMENTATION MUST ACCOMPANY APPLICATION)**

Patient's Name: _____ _____ _____
First Name M.I. Last Name

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____
Area Code and Phone Number

Date of Birth: _____ Social Security # _____ **PLEASE CIRCLE:** Male Female

Marital Status (PLEASE CIRCLE): Married Single Widowed Divorced Separated

Current Gross Annual Household Income (Including Social Security & Pension Benefits): _____

Number of household members dependent on income stated above (include applicant) _____

Are you a legal resident of the United States? _____ YES _____ NO

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Are you enrolled in any Government Prescription Coverage Programs? _____ YES _____ NO
(This includes Medicare Part D, Medicaid, Veteran's Administration and/or State or Local Programs

If you answered "yes", please provide name of program: _____

Are you enrolled in any Private Prescription Programs? _____ YES _____ NO
(This includes coverage through any private insurance, PPOs, HMOs)

If you answered "yes", please provide name of program: _____

Did you file a Federal Tax Return for the most recent year? _____ YES _____ NO

SECTION 3 – PATIENT CONSENT AND AUTHORIZATION:

I may refuse to sign this authorization; however, if I refuse to sign I will not be able to participate in the Program. I certify that all of the above statements and proof-of-income information provided are correct. I certify that I am not enrolled in the Medicare Part D Prescription Drug benefit or any other government or private prescription drug plan. I understand that if I enroll in any other prescription drug program (other than a Medicare Part D Prescription Drug Benefit plan) or private prescription drug plan, I may no longer meet the eligibility requirements of the Bayer Patient Assistance Program and will not be provided with free medication under it, even if the benefit program does not cover the full cost of, or places limits on, medications. I agree to notify the Bayer Patient Assistance Program immediately if I become covered under the Medicare Part D Prescription Drug benefit, or any other government or private prescription drug plan. In the event that I do enroll in a Medicare Part D Prescription Drug Benefit plan, I understand that I am still eligible to receive free medication under the Bayer Patient Assistance Program for this calendar year. I agree that I will not seek reimbursement from the Medicare Part D Prescription Drug Benefit plan or any other governmental program, whether state or federal, for any free product received under the Bayer Patient Assistance Program. Furthermore, I understand that the cost or value of any product received from the Bayer Patient Assistance Program will not be applied towards any required payments of True Out-of-Pocket expenses in connection with Medicare. I agree to provide the Bayer Patient Assistance Program with documentation to verify that the information provided is correct, including bank statements, Federal Tax Returns, verification of non-filing for Federal Tax, W-2 forms, denial from insurance companies or state or government programs, etc.

I understand that Bayer may discontinue or modify the Bayer Patient Assistance Program at any time; although medication may be given to me without cost now, it does not mean that I will be entitled to receive it without cost indefinitely. I understand that the eligibility for enrollment in the Bayer Patient Assistance Program is subject to Bayer's approval. No patient will be accepted into the program without the healthcare provider's and patient's (or legal representative's) original signature on this application. Bayer reserves the right to make a separate, independent determination of patient eligibility. **I agree to notify Bayer Patient Assistance Program immediately of any changes that might affect my eligibility.**

This information is for the sole use of Bayer and/or its representative(s) to determine eligibility for assistance and administering the Bayer Patient Assistance Program. Unless required by law, information will not be provided in an identifiable form to any other persons unless the patient agrees to the release in writing. This authorization will become effective when signed below and will remain in effect until revoked by the patient. A photocopy of this form is as valid as the original.

Please Print Patient's Name

Signature of Patient or Legal Representative Date

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Patient Assistance Program Guidelines
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The Bayer Patient Assistance Program provides **Betapace®** (sotalol HCl)**, Betapace AF®** (sotalol HCl), **Angeliq®** **(**Drospirenone/Estradiol), **Climara®** (Estradiol transdermal system), **Climara Pro®** (Estradiol/Levonorgestrel transdermal system), **Menostar®** (Estradiol transdermal system), **Precose®** (acarbose tablets), **CIPRO®** (ciprofloxacin hydrochloride) Tablets, **CIPRO®** (ciprofloxacin) ORAL SUSPENSION, **Biltricide®** (praziquantel) and **Adalat®cc** (Nifedipine) for patients in need of these drugs, who have no prescription coverage and limited financial resources. All applications are reviewed on a case-by-case basis. Bayer reserves the right to make a separate, independent determination of patient eligibility and to modify or discontinue the Bayer Patient Assistance Program, at any time.

Eligibility:

To be accepted into the Bayer Patient Assistance Program, a patient must be a legal resident of the United States.

Any patient who is enrolled in any Government Prescription Programs **(**other than a Medicare Part D Prescription Drug Benefit plan) or Private Prescription Plans including, but not limited to **Medicaid, State-sponsored Prescription Assistance programs, or has employee, military, retirement, or pension program drug coverage is not eligible** for the Bayer Patient Assistance Program.

If the patient receives benefits from any of these types of programs or plans, the Bayer Patient Assistance Program cannot provide medication, even if the benefit program or plan does not cover the full cost of, or places limits on, medications. **In the event that the patient does enroll in a Medicare Part D Prescription Drug Benefit plan, the patient will still be eligible to receive free medication under the Bayer Patient Assistance Program for this calendar year.** **Pharmacy discount cards or pharmaceutical assistance programs are not insurance coverage. You may still apply if you participate in these programs.

Application Process:

The patient should first seek any available state or government assistance (Medicare Part D, State Prescription programs, Veteran's Assistance, etc.) before applying to the Bayer Patient Assistance Program. The patient may be asked to supply paperwork supporting the denial of assistance from the programs mentioned above.

Once it has been determined that the patient may be eligible for the Bayer Patient Assistance Program, the Doctor/Prescriber's office should call our toll-free number: **1-866-575-5002** between 9 am and 5 pm EST. We will fax the necessary paperwork to enroll the patient.

All forms must be completed by the Doctor/Prescriber and the patient and returned with current income documentation. Once the forms are completely filled out, they can be faxed or mailed back to us. A copy of all documentation should be kept for your records.

Proof of Income:

Include **copies** of:

1. Federal Tax Return (Form 1040/1040EZ) for the prior tax year (Please include all Tax schedules).
2. Wage and tax statements (W2) for both patient and spouse (if patient is married)
3. Social Security, Pension or Railroad Retirement statements (SSA-1099 or similar)
4. Statements of Interest, dividends or other income (1099-INT, 1099-DIV, 1099 or other forms)

Patient must report **all** income, including salary, pension, Social Security, etc. for patient and spouse. If the patient does not file an income tax return, they must provide a statement from the IRS stating that they do not file. If the patient has no source of income, please provide us with a letter of means of support (i.e. Food stamps, housing assistance, or any other assistance received).

The Bayer Patient Assistance Program fax number and address are on the forms. **Incomplete forms will be returned and will delay processing time.**

Note:

1. It is important that an office fax number be provided since the majority of our correspondence with the prescriber's office is done via fax.
2. **We cannot ship to the patient's home, nor can we ship to a Post Office Box. We must have a street address in order to ship. If there is a suite number, please be sure to include that on the form.**
3. Accepted shipments are the responsibility of the Doctor/Prescriber's office. We cannot reship lost or misplaced medication once it has been signed for by the office.
4. If a patient no longer requires our assistance, we request that the patient or prescriber's office notify us immediately of this change.
5. No third party or patient will be charged for free product. No free product will be sold, traded or distributed for sale. Neither the patient nor the prescriber may seek reimbursement from any governmental program, including the Medicare Part D Prescription Drug Benefit plan for any free product received under the Bayer Patient Assistance Program and understand that the cost or value of any product received from the Bayer Patient Assistance Program **will not be applied towards any required payments of True Out-of-Pocket expenses in connection with Medicare.**