Forest Pharmaceuticals, Inc.
Subsidiary of Forest Laboratories, Inc. *Patient Assistance Program*
13645 Shoreline Drive • Earth City, MO 63045-1241 • (800) 851-0758

PATIENT ASSISTANCE PROGRAM

The Forest Pharmaceuticals, Inc. Patient Assistance Program ("FPI PAP") provides drug(s) or device(s) to qualifying applicants at no charge. If the applicant qualifies under FPI PAP guidelines, a three-month supply (as ordered by the applicant's prescriber) of the requested drugs(s) or device(s) will be shipped to the applicant's licensed prescriber for dispensing. The prescriber may dispense all or part of the three-month supply to the applicant in accordance with his or her medical judgment (provided any undispersed drug(s) or device(s) is returned to FPI).

APPLYING TO FPI PAP

Applicant

- The applicant is required to complete sections 1.0, 1.1, and 3.0 of the application. If the applicant is a Medicare Part D enrollee, he or she must also have applied for and been denied the Low-Income Subsidy ("LIS") from the Social Security Administration ("SSA").
- Attach a photocopy of the LIS denial letter to the FPI PAP application.
- The applicant must print his or her legal name exactly as it appears on his or her Social Security card.
- For the purposes of this program, gross monthly household income is defined as: (1) Monetary compensation for services, including wages, salary, commissions, or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security; (5) dividends or interest on savings or bonds or income from estates or trusts; (6) net rental income; (7) public assistance or welfare payments; (8) unemployment compensation; (9) government civilian employee or military retirement, or pensions or veteran's payments; (10) private pensions or annuities; (11) alimony or child support payments; (12) regular contributions from persons not living in the household; (13) net royalties; and (14) other cash income, including cash amounts received or withdrawn from any source including savings, investments, trust accounts, and other resources.
- To apply for LIS, please contact the SSA at 800-772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/.
- Please sign and date the certification section.

Licensed Prescriber

- The licensed prescriber is required to complete sections 2.0 and 4.0 and attach a prescription for a three-month supply of all FPI brand requested drug(s) or device(s). If the preprinted office address on the prescription does not match the delivery/mailing address on the FPI PAP application form, the licensed prescriber must also attach letterhead or a business card to verify the delivery/mailing address on the FPI PAP application form.
    - Please sign and date the certification section.. The prescription is not valid after 3 months.

DOCUMENTS TO SUBMIT TO FPI PAP

- Completed application and certifications signed by the patient and the licensed prescriber.
- Original valid prescription written for a three-month supply of drug(s) or device(s) from the licensed prescriber who signed the application.
- Photocopy of applicant's LIS denial letter (Medicare Part D enrollees only). The date on LIS denial letter is valid for 5 years (or such shorter time in accordance with Medicare guidance) and will be kept on file by the PAP office until it expires or the FPI PAP program terminates, whichever comes first.
- A signed and notarized Power of Attorney (POA) if application is completed by patient's authorized representative.

APPLICATION PROCESSING

Please allow 4 weeks for application processing and delivery of drug(s) or device(s).

- If the applicant is approved, a three-month supply of the drug(s) or devices(s) requested will be shipped to the licensed prescriber's office for dispensing in accordance with the prescription. If you would like notification of the ship date for the requested drug(s) or device(s), please supply FPI PAP with your email address in the appropriate space on the application.
- If the applicant is denied, the licensed prescriber and applicant will be notified by mail.
- Incomplete applications will be returned to the applicant or licensed prescriber as appropriate with instructions for completion.

SUBSEQUENT DRUG(S) OR DEVICE(S) SUPPLIES

Each time a qualifying applicant requires a three-month supply of FPI drug(s) or device(s) a new FPI PAP application form with original signatures or applicable POA, original valid prescription, and photocopy of the LIS denial letter (Medicare Part D enrollees) unless currently on file, must be submitted by mail to FPI PAP. You may make photocopies of the blank FPI PAP application form for future use.

NO FEES APPLY TO THIS PROGRAM.

The following branded drugs and devices are available through the Forest Pharmaceuticals, Inc. Patient Assistance Program

DRUG:	STRENGTH(S):	SIZE:
Armour® Thyroid (thyroid tablets, USP)	¼ gr, ½ gr, 1 gr, 1½ gr, 2 gr, 3 gr, 4 gr, 5 gr	100 ct. bottle
Bystolic® (nebivolol) Tablets	2.5 mg, 5 mg, 10 mg, 20 mg	100 ct. bottle
Campral® (acamprosate calcium) Delayed-Release Tablets	333 mg	180 ct. bottle
Daliresp® (roflumilast) Tablets	500 mcg	30 ct. bottle
Fetzima™ (levomilnacipran) Extended Release Capsules	20 mg, 40 mg, 80 mg, 120 mg	30 ct. bottle
Fetzima™ (levomilnacipran) Extended Release Capsules Titration Pack	20 mg and 40 mg combination pack	2 x 20 mg capsules; 26 x 40 mg capsules
Linzess® (linaclotide) Capsules	145 mcg, 290 mcg	30 ct. bottle
Namenda® (memantine HCl) Tablets	5 mg, 10 mg	60 ct. bottle
Namenda® (memantine HCl) Oral Solution	10 mg = 5 mL	360 mL bottle
Namenda® (memantine HCl) Titration Pack	5 mg and 10 mg combination pack	28 x 5 mg tablets; 21 x 10 mg tablets
Namenda XR® (memantine HCl) Extended Release Capsules	7 mg, 14 mg, 21 mg, 28 mg	30 ct. bottle
Namenda XR® (memantine HCl) Extended Release Capsules Titration Pack	7 mg, 14 mg, 21 mg, and 28 mg combination pack	7 x 7 mg capsules; 7 x 14 mg capsules; 7 x 21 mg capsules; 7x 28 mg capsules
Savella® (milnacipran HCl) Tablets	12.5 mg, 25 mg, 50mg, 100 mg	60 ct. bottle
Savella® (milnacipran HCl) Titration Pack	12.5 mg, 25 mg and 50 mg combination pack	5 x 12.5 mg tablets; 8 x 25 mg tablets; 42 x 50 mg tablets
Tudorza® Pressair® (aclidinium bromide inhalation powder)	400 mcg	60 meter dose
Viibryd® (vilazodone HCl) Tablets	10 mg, 20 mg, 40 mg	30 ct. bottle
Viibryd® (vilazodone HCl) Patient Starter Kit	10 mg, 20 mg, and 40 mg combination pack	7 x 10 mg tablets; 7 x 20 mg tablets; 16 x 40 mg tablets
AeroChamber Plus® Flow-Vu Mouthpiece*/ Flow-Vu Mask*	**DEVICE:**	Small, Medium, Large

* Maximum amount for AeroChamber or AeroChamber with mask is one per applicant in a six-month period.

Controlled substances and generic drugs and devices are not available through the Forest Pharmaceuticals, Inc. Patient Assistance Program.

← Staple RX behind completed application; additional information behind RX.

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FOREST PHARMACEUTICALS, INC. ▪ Patient Assistance Program

13645 Shoreline Drive • Earth City, MO 63045-1241 • (800) 851-0758 • Fax (636) 754-0570

www.forestpharm.com/pap

For FPI Product Information: (800) 678-1605

SECTION 1.0: PATIENT INFORMATION

First Name (Legal):	MI:	Last Name:	Gender: ☐ F ☐ M
Phone Number:	Social Security Number:		Date of Birth:
Mailing Address:	Apt. Number:	PO Box:	
City:	State:	Zip Code:	
Marital Status:	Email Address:		

Gross Monthly Household Income: (see "Applying to FPI PAP")

Number of People in Household (include yourself):

SECTION 1.1: OTHER COVERAGE INFORMATION

Are you enrolled in Medicare? ☐ Yes ☐ No

Are you enrolled in Medicaid? ☐ Yes ☐ No

Medicare ID #:

Are you enrolled in a Medicare Part D plan? ☐ Yes ☐ No

Medicare Part D enrollees: You must have applied for and been denied the Low-Income Subsidy ("LIS") from the Social Security Administration ("SSA") before submitting this application to FPI PAP. To apply for LIS, please contact the SSA at (800) 772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/. Please attach a photocopy of your LIS denial letter to this application. We are unable to accept a pre-decisional notice.

Have you attached a photocopy of your Medicare Part D LIS denial letter? ☐ Yes ☐ No

Do you have prescription coverage/reimbursement other than Medicare Part D at any time during the year? ☐ Yes ☐ No

If yes, please provide the following information regarding your primary and any secondary insurance company (attach additional sheets, if necessary):

Plan name: _____ Policy holder name: _____

Policy ID#: _____ Group #: _____

What is the co-pay/reimbursement under your plan for the requested medication? _____

Has your insurer denied coverage for the requested medication? ☐ Yes ☐ No

SECTION 2.0: LICENSED PRESCRIBER INFORMATION

First Name (Legal):	MI:	Last Name:	Professional Designation:
State License Number:	DEA Number:	NPI Number:	
Mailing Address:	Ste. Number:	PO Box:	
City:	State:	Zip Code:	
Delivery Address (must be authorized to accept prescription drugs):	Ste. number:	PO Box:	
City:	State:	Zip Code:	
Office Contact Name:	Phone Number:	Ext:	

Attach valid prescription(s) for Forest brand drug(s) or device(s) to this application.

PATIENT AND LICENSED PRESCRIBER MUST SIGN & DATE THE CERTIFICATIONS ON PAGE 2 OF THIS APPLICATION.

FOR FPI PAP USE ONLY

Audited	Entered	PAP
By/Date:	By/Date:	Order ID:

#85-13000006

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SECTION 3.0: PATIENT CERTIFICATION

I certify that I do not have the ability to pay for the drug(s) and/or device(s) requested by my licensed prescriber on the prescription attached to this application and that all information provided in sections 1.0 and 1.1 is correct and complete. I understand that Forest Pharmaceuticals, Inc. Patient Assistance Program ("FPI PAP") is entitled at any time to request verification of any such information which I agree to provide from me, my employer, and/or my insurer. I understand that FPI PAP may contact me for verification of my application status and receipt of the indicated drug(s) and/or device(s). I understand that if approved, I am not eligible to, and I certify that I will not seek reimbursement for any drug(s) and/or device(s) requested on the prescription attached to this application from any government program or third party insurer, and that I will not sell, trade, or distribute the FPI PAP drug(s) and/or device(s). I understand my eligibility or continued eligibility under the FPI PAP is subject to FPI's discretion and that FPI reserves the right to modify or terminate the PAP at any time. I understand that if I am approved for FPI PAP, my prescriber will receive a three-month supply of drug(s) or device(s) to dispense to me and that I must re-apply to FPI PAP each time I need drug(s) or device(s).

I also understand and certify that if I am a Medicare Part D enrollee, I will not apply or claim any FPI PAP drug(s) and/or device(s) towards True-Out-Of-Pocket ("TrOOP") costs. If I am enrolled in a Medicare Part D Plan, the FPI PAP will not deny my re-application during a Medicare Part D plan year based on a change relating to availability of Part D coverage (except for LIS eligibility).

I authorize my prescriber to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act ("HIPAA") and regulations thereunder, as well as other state or federally protected personal information) to FPI PAP or third parties engaged, as required to assist FPI in administering the FPI PAP. I understand that as part of that process, FPI PAP may disclose my PHI to Centers for Medicare & Medicaid Services ("CMS") (and/or CMS's authorized vendor) for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in FPI PAP with my Medicare Part D plan. I understand that my PHI will consist of my name, address, Social Security number, income, prescription coverage, prescription for drug(s) or device(s), financial documents and insurance records and will be used for purposes of determining my eligibility to participate in FPI PAP and to ship appropriate drug(s) and/or device(s) as prescribed by my licensed prescriber. I further understand that if my PHI is incomplete or my completed PHI does not allow me to participate in FPI PAP that I may be notified of such by FPI PAP. I understand that upon the furnishing of my PHI to FPI PAP, my PHI may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I may revoke this authorization at any time by providing written notice to FPI at the address set forth above. My revocation will become effective on the date my written notice is received and processed at FPI PAP. If I revoke my authorization, I understand this means I may no longer be able to receive assistance from the FPI PAP. I also understand that I may refuse to sign this form and that doing so will not affect my prescriber's treatment of me or my eligibility for insurance benefits.

Patient or Legal Guardian's **ORIGINAL** Signature or Signed Notarized POA must be attached (ink other than black):	Date (request valid for three months):
X	**X**

SECTION 4.0: LICENSED PRESCRIBER CERTIFICATION

My signature certifies that I am a licensed prescriber eligible under state law, my collaborative agreement and formulary, if applicable, to prescribe, receive, and dispense the requested drug(s) and/or device(s) listed on this application, shipped from Forest Pharmaceuticals, Inc. (FPI). I further certify all information provided in section 2.0 and on the attached prescription is correct and complete and agree to submit appropriate verification of such information upon FPI's reasonable request. I agree that drug(s) and/or device(s) provided to me by FPI pursuant to prescriptions provided by me for the applicant named in 1.0 will be provided by me to such eligible applicant for his or her own use without charge. I will not otherwise use any of such drug(s) and/or device(s) or prescribe, provide, or dispense all or any portion thereof for the use of any other person. I consent that FPI or its designee may contact the applicant named in section 1.0 for verification of applicant status and receipt of the indicated drug(s) and/or device(s). I further consent that FPI may perform an on-site audit of PAP records related to the applicant named in 1.0 of this application. I understand that I am not eligible to, and I certify that neither I nor my office will: (i) seek reimbursement for any drug(s) or device(s) dispensed by FPI PAP from any individual, government program, or third-party insurer; (ii) return any drug or device dispensed by FPI PAP for credit; (iii) sell, trade, or distribute this drug or device; or (iv) apply any FPI PAP drug(s) or device(s) towards the applicant's Medicare Part D TrOOP (if applicable). I further understand that I cannot seek payment for an office visit from the applicant or third-party insurer when FPI PAP drug(s) or device(s) is provided to the applicant. I also understand that an individual patient's eligibility or continued eligibility under the PAP is subject to FPI's discretion and that FPI reserves the right to modify or terminate the PAP at any time. I further understand my enrollment is subject to FPI's discretion and FPI reserves the right to terminate at any time.

Licensed Prescriber's **ORIGINAL** Signature (ink other than black):	Date (request valid for three months):
X	**X**

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