FOREST PHARMACEUTICALS, INC.

Patient Assistance Program
13645 Shoreline Drive • Earth City, MO 63045-1241 • (800) 851-0758

FPI PATIENT ASSISTANCE PROGRAM

The Forest Pharmaceuticals, Inc. (FPI), Patient Assistance Program provides medication for qualifying patients at no charge. If the patient qualifies under FPI guidelines, a three-month supply of the requested drug(s) or device(s) will be shipped to the patient's licensed practitioner for dispensing to the patient. The latest version of this application has a revision date of 1/06. Please discard all unused copies of earlier versions of the application.

Applying for the Program

To apply for the program:

- The patient and licensed practitioner must complete and sign the Patient Assistance Program application form, and the licensed practitioner must attach a prescription (Rx), for a three-month supply, for each drug or device being requested.

Note: If the delivery address on the Rx does not match the delivery or mailing address on the Patient Assistance Program application form, then the licensed practitioner must also attach letterhead or a business card to verify the delivery or mailing address.

Submittal Information

Completed Patient Assistance Program application forms, along with the required prescriptions must be sent to the address at the top of the page.
Note: Copies of a blank Patient Assistance Program application form may be made for future use. However, FPI WILL NOT ACCEPT faxes, emails, or copies of a completed application form.

Application Processing

Please allow 4 weeks for application processing and delivery of medication.

- If the patient is approved, a three-month supply of the drug(s) or device(s) requested will be sent to the licensed practitioner's office for dispensing.
- If the patient is denied, the licensed practitioner and patient will be notified by mail.
- Unless stated otherwise, incomplete applications will be returned to the licensed practitioner or the patient with instructions for completion.
- If you would like notification of the ship date for the requested medication, please write your e-mail address in the space provided.

Applying for Refills

Each time a qualifying patient's prescription needs refilled, a new Patient Assistance Program application form and Rx must be submitted to FPI.

NO FEES APPLY TO THIS PROGRAM.

The following products are available on this program

MEDICATION	STRENGTH	SIZE
Aerobid® Inhaler	NA	7 gm canister
Aerobid® M Inhaler	NA	7 gm canister
* Aerochamber®	NA	NA
* Aerochamber® w/Mask	NA	Sm, Reg, Lg
Armour® Thyroid Tablets	1/4, 1/2, 1, 1 1/2, 2, 3, 4, 5 gr	100 ct. bottle
Campral® Dose Pak	333mg	180 ct. Pak
Campral® Tablets	333mg	180 ct. bottle
Celexa™ Tablets	10, 20, 40 mg	100 ct. bottle
Kay Ciel® Powder Packets	NA	100 ct. pack
Levothroid® Tablets	25, 50, 75, 88, 100, 112, 125, 137, 150, 175, 200, 300 mcg	100 ct. bottle
Lexapro™ Tablets	5, 10, 20 mg	100 ct. bottle
Tessalon® Perles	100, 200 mg	100 ct. bottle
Theochron™ Tablets	100, 200, 300 mg	100 ct. bottle
Thyrolar® Tablets	1/4, 1/2, 1, 2, 3	100 ct. bottle
Tiazac® Capsules	120, 180, 240, 300, 360, 420 mg	90 ct. bottle

* Maximum amount for Aerochamber® or Aerochamber® with Mask is one per patient in a six-month period.

Controlled substances are not available on the Patient Assistance Program.

STAPLE RX to BACK of application. Additional information BEHIND RX rev. 1/06

Forest Pharmaceuticals, Inc. • PATIENT ASSISTANCE PROGRAM

13645 Shoreline Drive • Earth City MO 63045-1241 • (800) 851-0758 • www.forestpharm.com/pap

For FPI Product Information: (800) 678-1605

PART I: PATIENT INFORMATION

New Applicant: ☐ Yes ☐ No

Name: ______________________ (First MI Last) **Phone #:** ____________

Mailing Address: ______________________ (Address P.O. Box City St. Zip)

Date of Birth: ____________ **Marital Status:** ____________ **Number in Household:** ________

E-mail Address: ______________________

What is your gross monthly household income? $ ____________ Do you have Medicare Part D? ☐ Yes ☐ No

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

If yes, please provide your carrier's name & any benefits received for the requested medication:

____

____

By signing below, I authorize my physician to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, "HIPAA") to Forest Pharmaceuticals, Inc. ("FPI") or third parties engaged to assist FPI in administering the FPI Patient Assistance Program ("PAP"). I understand that my PHI will consist of my name, address, income, prescription coverage, and prescription for medication and will be used for purposes of determining my eligibility to participate in the PAP and to ship appropriate medication(s) as prescribed by my licensed medical practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in PAP that I may be notified of such by FPI PAP. I understand that upon the furnishing of my PHI to FPI, my PHI may not be subject to all of the protections and safeguards provided by HIPAA. I may revoke this authorization at any time by providing written notice to FPI at the address set forth above. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I certify that I do not have the ability to pay for the medication(s) submitted on this application by my licensed medical practitioner and the information I have provided in PART I is correct and I understand that FPI is entitled at any time to request verification of any of such information which I agree to provide. I consent that FPI may contact me for verification of my application status and receipt of the indicated medication(s). I understand 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.

______________________ ____________

Patient's **ORIGINAL** signature Date

PART II: LICENSED PRACTITIONER INFORMATION

Practitioner Name: ______________________ **Professional Designation:** ____________

St. License #: ____________ **DEA #:** ____________ **Phone #:** ____________

Office Contact: ______________________ **E-mail Address:** ____________

Mailing Address: ______________________ (Address Suite # City St. Zip)

Delivery Address: ______________________ (Address Suite # City St. Zip)

Medication	Strength	Daily Dose

Attach a prescription(s) to this application.

By signing below, I certify that the information I have provided in PART II is correct and agree to submit appropriate verification of such information upon FPI's reasonable request. I agree that medication(s) provided to me by FPI pursuant to prescriptions provided by me for an eligible participant in the PAP will be provided by me to such eligible participant for his or her own use without charge and I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person. I further consent that FPI may contact the patient listed in PART I for verification of patient status and receipt of the indicated medication(s). I understand that 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.

______________________ ____________

Licensed Practitioner's **ORIGINAL** signature Date

FOR FPI OFFICE USE ONLY

Status: A or D By/Date: **Entered By/Date:** **PAP Number:**

Faxed Applications will not be accepted.

STAPLE RX to BACK of application. Additional information BEHIND RX

STAPLE RX to BACK of application. Additional information BEHIND RX

FOLD HERE

FOREST PHARMACEUTICALS, INC.
Subsidiary of Forest Laboratories, Inc.
13600 SHORELINE DRIVE • ST. LOUIS, MISSOURI 63045

Place
Postage
Here

FOREST PHARMACEUTICALS INC
SUBSIDIARY OF FOREST LABORATORIES INC
PATIENT ASSISTANCE PROGRAM
13645 SHORELINE DR
EARTH CITY MO 63045-1241

FOLD HERE

STAPLE OR TAPE CLOSED