

Thank you for your interest in the TEVA CARES FOUNDATION Patient Assistance Program which provides prescription medicines at no cost to patients who qualify. If you have no insurance coverage for the drug and meet the program income guidelines, you may qualify for this program. Please complete and submit this application to determine if you qualify. Each application will be considered on a case by case basis.

PATIENT INSTRUCTIONS: (An incomplete application will delay processing)

1. Complete ALL fields on page 1.
2. Refer to TevaCares.org for complete eligibility guidelines of the program.
3. Read the Patient Certification and Patient Authorization to Use and Disclose Protected Health Information statements on Page 2. IMPORTANT: Provide printed and signed name, and date of signature in the spaces provided after each statement.
4. Proof of income is required from all sources and for all members of your household (you, your spouse and your dependents). Provide Proof of Income in one of two ways:
 - For your convenience, let us verify your income securely and electronically by consenting to Electronic Income Verification on Page 3, OR
 - Attach Proof of Income, which may include one or more of the following:
 - A copy of your most recently filed Federal Income Tax Return or Forms (1040, 1040SR, 1099, 1099-DIV or 1099-INT)
 - Social Security Income Yearly Benefits Statement (SSA, 1099-R, or Awards Letter)
 - IRS Transcript
 - Three of most recent Pay stubs
 - Unemployment Letter or Worker's Compensation
 - Veterans Benefits, Alimony/Child Support, Rental Income, etc.
 - Employer Letter on Company Letterhead
 - Letter from HCP, social worker, case worker, or clergy verifying patient has no income
5. Coordinate with your physician to submit the completed application and proof of income as described below.
6. Medicaid patients limited to family planning or a plan without a prescription coverage must provide proof of plan.
7. LIS-eligible patients with a plan-covered medication who are denied LIS assistance are required to submit proof of that denial. For those who's medication is not covered by the plan, a proof of plan exclusion will be required.

PHYSICIAN INSTRUCTIONS: (An incomplete application will delay processing)

1. Complete the Prescription Information section on page 4. Attach a separate prescription if required by your state's prescription laws.
2. **For All Insured Patients:** Where an appeal is required: (i) submit a claim to the patient's insurance company; (ii) if the claim is denied, submit an appeal to the patient's insurance company, prior to requesting free product under this Program; and (iii) provide documentation of the initial denial and appeal denial to the Program. Application will be considered incomplete and will not be processed until documentation is received by the Program. Patients may not have an insurance plan or employer that participates in or are involved in any way with an alternative funding program that requires or encourages you to apply to the Teva Cares Patient Assistance Program as a condition, requirement, or prerequisite for coverage of specific Teva products.
3. Read the certification language and sign the application as indicated on page 5.
4. If a prescription is faxed, it must be sent directly from the physician's office
5. Coordinate with your patient to submit the completed application by fax or mail:
 - Fax everything to: 1-877-438-4404
 - Mail to: TEVA CARES FOUNDATION
Patient Assistance Program
PO Box 501827
San Diego, CA 92150
6. Complete the Product Shipment information on page 4.

If you have any questions please call the program at 877-237-4881. We are available to answer your call Monday through Friday, from 9:00am to 8:00pm Eastern Time (excluding holidays).

PATIENT INFORMATION:

Patient Name (First): _____ (MI): _____ (Last): _____
 Last 4 Digits of SSN: _____ Date of Birth: _____
 Mailing Address: _____ Phone: _____
 City: _____ State: _____ ZIP: _____
 Patient is Homeless: Email: _____ US Resident? YES NO
 Contact Name (if other than patient): _____ Contact Phone: _____

FINANCIAL INFORMATION:

Number of people in your household including you, your spouse and your dependents: _____
 Total Annual Income for your household listed above (Adjusted Gross Income): \$ _____

INSURANCE INFORMATION:

Please provide legible copies of the front and back of all insurance cards (enlarged if possible)

What type of health insurance do you have? (check all that apply)

I do not have health insurance

Medicare

- Medicare Part A
- Medicare Part B without supplemental/secondary Insurance
- Medicare Part B with supplemental/secondary Insurance
- Medicare Advantage Plan
- Medicare Part D

Other Insurance Type

- Employer provided or other private/commercial insurance
- VA or Military or a spouse or dependent of a Veteran who is eligible for VA benefits?
 If yes, have you applied for VA benefits? YES NO
- Medicaid: What is your Medicaid status for the past 12 months? Not applied Denied Pending
 Medicaid Provider # _____
 Medicaid Provider Pin: _____

Policy Holder's First Name:	Last Name:	Date of Birth:

For each policy you have, including any secondary coverage, provide the following:

Insurance Name:	Phone #:	ID / Policy #:
Primary: _____	_____	_____
Secondary: _____	_____	_____


- Please check this box if your insurance plan or a third party requires you to apply to the Teva Cares Program as a condition, requirement, or prerequisite for coverage of a specific Teva Cares medication.
- For UZEDY (risperidone) extended release injectable suspension, please check here to authorize the pharmacy to ship the medication to your physician's office.

PATIENT CERTIFICATION:

I certify that the information I have provided is truthful and accurate to the best of my knowledge. I understand that any assistance provided to me through the Teva Cares Foundation ("The Foundation") Patient Assistance Program (the "Program") is contingent upon my ability to meet the eligibility criteria for the Program as established by The Foundation and that my application for assistance does not guarantee acceptance into the Program. Any assistance for which I may be eligible will only be awarded after my documentation has been received and approved by the Program. In the event that I am eligible for the Program, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Program. Assistance is not guaranteed for any specific time frame and may be terminated at any time for any reason without any notice to me. I agree that I will notify the Program within thirty (30) days if my insurance or financial situation changes as this may impact my eligibility to participate in the Program. The Program has the right to review its records periodically throughout a patient's enrollment period to verify that the enrolled patient continues to satisfy the eligibility criteria. If this review determines that the patient no longer satisfies the eligibility criteria, the PAP will withdraw the patient from the Program. I certify that I have not received and will not seek to receive reimbursement for the Teva drug requested and/or supplied through the Program. I agree that the Program and its affiliates, agents and representatives shall not be liable for any damages, of any kind, without limitation, in connection with my receiving assistance, benefits, or services provided by the Program. I have read, understand, and agree to all of the above.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority or relationship to patient: _____

 Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required. You may be required to provide Power of Attorney documentation, if applicable.

Signature
Required**PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:**

I authorize my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to the Teva Cares Foundation ("The Foundation") and its affiliates, contractors and agents, including its third party patient assistance Program service provider (collectively "Teva") for the purposes described below. I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition, including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) providing me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to the Program. I understand that I may cancel this Authorization at any time, by writing to Teva Cares Foundation, Attn: Authorizations, PO Box 501827, San Diego, CA 92150, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to re-disclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority or relationship to patient: _____

 Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required. You may be required to provide Power of Attorney documentation, if applicable.

Signature
Required

Provide Proof of Income by selecting one of the two options below.

- Electronic Income Verification: Consent is required for us to electronically verify your income. Provide your consent below.
OR
- Income Documentation: Attach copies of Proof of Income from all sources – see complete list of acceptable documents in Patient Instructions on the cover page.

FAIR CREDIT REPORTING ACT PATIENT CONSENT FOR ELECTRONIC INCOME ESTIMATION:

I am providing 'written instructions' under the Fair Credit Reporting Act to the Program, including its agents, administrators and service providers, authorizing the Program to obtain information from my credit profile and/or other information from Experian Health. I authorize the Program, including its agents, administrators, and service providers, to obtain such information solely to determine my eligibility to participate in the Program. I understand this is a soft inquiry that will not affect my credit score or be visible to lenders viewing a credit report. I also understand that if my income cannot be estimated electronically, or if my estimated income determines me ineligible, the Program will reach out to me for proof of income documentation. I further understand that upon request, the Program will inform me whether it accessed this information and the name and address of the agency that furnished it.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority or relationship to patient: _____

 Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required. You may be required to provide Power of Attorney documentation, if applicable.

Signature
Required**TELEPHONE CONSUMER PROTECTION ACT AUTHORIZATION:**

By signing, I agree to receive autodialed phone or text messages ("texts") at the mobile phone number I have provided for the purpose of helping me/the patient stay on therapy, which may promote or advertise for Teva products.

The types of messages would include, but are not limited to, program opt-in / opt-out, application status, and medication shipment notifications. I certify that the number I am providing belongs to me and not a family member or third party.

I understand that I may opt out of individual communications of the Program entirely at any time by calling 877-237-4881 clicking the email link in a message received or by replying "STOP" by text to any text from Teva Cares.

Teva Cares will not sell or rent this information and will use it only in accordance with this authorization and consent. Please visit SMS Terms www.pssmobileterms.com and www.tevausea.com/general-pages/us-privacy-center for more information.

Consent to being contacted by email, phone or text messages is not a condition of participation in the Programs or the purchase of any products or services. I understand that my cellular service carrier's data and text messaging rates may apply. Message frequency may vary.

If I am providing this consent on behalf of another person, I certify that I am authorized to agree to every element of this consent on behalf of such other person, and I agree that I will be liable and will hold Teva Cares harmless in the event that such other person alleges that they did not give consent.

Print Patient or Personal Representative Name: _____

If Personal Representative, please state legal authority or relationship to patient: _____

 Patient or Personal Representative Signature: _____ Date: _____

*If signed by Personal Representative, we may contact you if additional documentation is required. You may be required to provide Power of Attorney documentation, if applicable.

Signature
Required

Prescriber: Please attach a separate prescription if required by your state's prescription laws.
Incomplete information on the application may result in delays in processing.

PRESCRIPTION:

Patient Name (First): _____ (MI): _____ (Last): _____

Address: _____ Date of Birth: _____

City: _____ State: _____ ZIP: _____

Medication Allergies: _____ Medications Currently Taking: _____

Is patient being treated an outpatient: YES NO

Therapy GIVEN			Therapy PLANNED for month		
Date(s)	Dose	Frequency	Date(s)	Dose	Frequency

Medications Available: A list of medications available through the Teva Cares Foundation Patient Assistance Program is available at www.TevaCares.org

Product Requested:	Strength:	Quantity:	Frequency/Directions:	Refills:
_____	_____	_____ month(s) supply	_____	<input type="checkbox"/> _____ <input type="checkbox"/> 1 Year

ICD-10 Diagnosis Codes: _____

Reminder for AJOVY (fremanezumab-vfrm) in pediatrics

Please note when prescribing AJOVY in pediatric patients with episodic migraine, the FDA-approved indication specifies use for patients aged 6 to 17 who weigh 45 kg or more. AJOVY is not approved for pediatric patients who weigh less than 45 kg due to a lack of an appropriate strength presentation.

SHIPPING:

Ship to Patient Ship to Office


If shipping address is different than the address provided, list below.

Medication Shipping Address:

City: _____ State: _____ ZIP: _____

Your state may require that prescriptions follow certain requirements or use a particular form. By signing below, you certify that you are abiding by laws applicable to prescriptions and authorized prescribers in the states in which you are prescribing. I authorize Teva Cares Foundation to act on my behalf for the limited purposes of transmitting this order for prescription medication.

PRESCRIBER SIGNATURE: Prescriber signature must be the same as Prescriber name. Stamped/computer-generated signatures are NOT permitted - ink signature only

 Prescriber's Signature: _____ Date: _____
 Signature Required Prescriber Name: _____ Prescriber NPI #: _____
 Prescriber Email: _____

FACILITY INFORMATION:

Facility Name: _____

Facility Address: _____

City: _____ State: _____ ZIP: _____

Clinic Contact: _____

Contact Title: _____

Contact Phone: _____ Ext: _____

Contact Fax: _____

PHYSICIAN CERTIFICATION:

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 based upon my professional judgment, the drug I have prescribed and specified in this application is medically necessary. I authorize Teva Cares Foundation and its affiliates, business partners, and agents to forward, as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva Cares Foundation. Should any information contained in this form change, I agree to notify a Program representative. I understand that the patient must meet certain financial criteria to be eligible under the Program and that completing this enrollment form does not guarantee that assistance will be provided to my patient. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested and/or supplied under the Program and any administration charges will be consistent with my practice's standard policies for treatment of and charges to financially needy patients. I certify that no free product provided under this Program will be distributed for sale to any individual or organization or returned for credit. I understand that the Teva Cares Foundation reserves the right to modify or terminate this Program at any time for any reason without any prior notice. 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.

 Prescriber Signature: _____ Date: _____Signature
Required

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