

Graceway Pharmaceuticals Patient Assistance Program
PO Box 8202
Somerville, NJ 08876
Phone: (866) 628-6498
Fax: (866) 838-5820

Application Checklist:

- Complete Patient Information & Eligibility Section.
- Complete Healthcare Practitioner Section.
- Attach a brand name prescription** for a 3 month supply of medication to the application.
- Attach copy of the patient's most recent Federal Tax Return (1040 or 1040A) or Social Security Income (SSA 1099). (This information is required annually.)
- Completed application along with a prescription can be faxed or mailed to the address listed above.

Once the information is received:

- Medication will be sent to the healthcare practitioner for all approved patients.
- Both the patient and healthcare practitioner will be advised in writing if a request is denied.
- All incomplete applications will be sent to either the patient or healthcare practitioner for completion.

Program Eligibility

- Patient is a legal resident of the United States.
- Patient does not have and is not eligible for prescription drug coverage through any government program, such as Medicare (including Medicare Part D), Medicaid, or any other federal or state healthcare program.
- Patient must not have any private prescription coverage such as a private health insurance, HMO or PPO.
- Patient's total annual household income must be **at or below** 200% of the Federal Poverty Level. See chart below for specific income amounts per household size.

| Household Size | Total Household Income |
|----------------|------------------------|
| 1 | \$20,420 |
| 2 | \$27,380 |
| 3 | \$34,340 |
| 4 | \$41,300 |
| 5 | \$48,260 |
| 6+ | \$55,220 |

Please note:

- The Graceway Pharmaceuticals Patient Assistance Program is intended to serve the indigent patient in need of short-term therapy. The program is not intended to promote sales.
- Approved patients will receive a 3-month supply. Product will be shipped to the prescriber.
- The Graceway Pharmaceuticals Patient Assistance Program reserves the right to modify or cancel this program at any time without notice.
- All requests are subject to product availability.

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PLEASE COMPLETE THIS FORM IN ITS ENTIRETY TO PREVENT ANY DELAYS IN PROCESSING.

1. Patient Information Section

Name _____ SS# _____
 Address _____ Date of Birth _____
 _____ Phone # _____
 City _____ State _____ Zip _____ Gender _____

2. Eligibility Section

- A. Is the patient a legal U.S. resident? Yes No
- B. Is the patient covered or eligible for prescription coverage in any government programs, including Medicaid, VA or any other federal, state or local programs? Yes No
- C. Is the patient covered or eligible for prescription coverage in any private programs, including private insurance, HMO's or PPO's? Yes No
- D. Does the patient have Medicare Part D coverage? Yes No
- E. Number of persons residing in household (including patient)..... _____
- F. Total **ANNUAL** household income, including social security and pension benefits\$ _____ **ANNUAL**

I verify that the information provided in this application is complete and accurate. I also certify that I am uninsured and ineligible for any type of public or private reimbursement or coverage of drug costs. I also certify that I am unable to afford the cost of the medication. I understand that Graceway Pharmaceuticals Patient Assistance Program reserves the right at any time and without notice to modify the application form, modify or discontinue this program and the related eligibility criteria, or to refuse to distribute any drugs under this program to any patient. I understand that I am expected to seek any available state or government assistance before reapplying to the Graceway Pharmaceuticals Patient Assistance Program. I authorize the Graceway Pharmaceuticals Patient Assistance Program to use the information on this application to process my request for medication from the program and authorize the use of my Social Security number for identification. I agree not to submit an insurance claim or any other claim for payment to any third-party payor (private or government) for the prescription product.

_____ _____
Patient Signature (must be original signature) **Date**

3. Healthcare Practitioner Information Section

Name _____ Phone # _____
 Address _____ FAX # _____
 (No P.O. Box) _____ State Lic # _____
 City _____ State _____ Zip _____ (Attach a copy of state license w/expiration date)
 Attention _____

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. I understand that the Graceway Pharmaceutical Patient Assistance Program reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from the Graceway Pharmaceutical Patient Assistance Program is for the use of the above named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that the Graceway Pharmaceutical Patient Assistance Program reserves the right to recall the product when necessary.

_____ _____
Signature of Licensed Prescriber (Must be original - No stamped signatures) **Date**