RAPAFLO® REIMBURSEMENT and PATIENT ASSISTANCE PROGRAM APPLICATION

PATIENT INFORMATION		
Name:	Date of Birth:	Gender:
Address:	SS# (Optional):	
City:	State:	Zip:
Phone:	Fax (if available):	

INSURANCE INFORMATION	
Primary Insurance Name:	**Secondary Insurance Name:**
Policy ID #:	Policy ID #:
Group #:	Group #:
Customer Service Phone #:	Customer Service Phone #:
Policyholder Name:	Policyholder Name:
Relationship to Patient:	Relationship to Patient:

FINANCIAL INFORMATION	
Household Size:	Annual Income:

CLINICAL INFORMATION

Patient Diagnosis: benign prostatic hyperplasia (BPH): ❑ 600.00 ❑ 600.01 ❑ Other____________________________________

Patient Dosage: ❑ 8 mg 90 capsules RAPAFLO® ❑ 4 mg 90 capsules RAPAFLO®

PROVIDER INFORMATION: Shipments will be made to prescribing physician

PRESCRIBING PHYSICIAN (Please include a prescription for RAPAFLO® when submitting applications)		
Name:		
NPI #:	State License #:	
Address:		
City:	State:	Zip:
Phone:	Fax:	
Site Name:	Tax ID #:	
Office Contact:		

Physician Consent: By signing below, I attest that the information on this form is correct and complete to the best of my knowledge. To the best of my knowledge, this patient does not have prescription drug coverage (including Medicaid, county-funded assistance, or other public programs) for RAPAFLO®. No claim may be made to any third party payer for payment, nor may any patient be charged, for product provided under the program. I understand that these goods may not be sold or traded and may not be returned for credit. If the patient is approved for assistance with RAPAFLO®, the product will be sent directly to my office for distribution to this patient. My signature confirms that there is a valid medical need for this patient's prescription and the information submitted upon this application is accurate.

If the physician's State License number is registered to an address different from the physician's shipping address, please check here ❑ and sign below to give consent to ship to the address listed on the form.

Physician Signature:	**Date:**

Applicant Declaration and Consent: I certify that the information on this form is true and complete to the best of my knowledge. I authorize the RAPAFLO® Reimbursement and Patient Assistance Program to obtain information from my physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of understanding my coverage for RAPAFLO®. I understand my information will be used solely for the purposes of eligibility for the RAPAFLO® Reimbursement and Patient Assistance Program and will not be shared for any other purposes except where disclosure is required by law. I understand that information will be shared with my physician and agents of Watson who administer the RAPAFLO® Reimbursement and Patient Assistance Program for treatment purposes. I also understand that Watson has the right to modify or discontinue the program without prior notification. This consent will last for one year from date of signing.

Patient's Signature:	**Date:**

P.O. Box 1265, San Bruno, CA 94066
PHONE: 1-866-676-4068 FAX: 1-866-676-4063
Hours of Operation: Monday through Friday between the hours of 9 AM to 5 PM (ET)

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