Patient Assistance Program Application

Thank you for your interest in the Bausch Health Patient Assistance Program (Bausch Health PAP).
This program is designed to provide assistance and access to individuals in need of products made available through the Bausch Health PAP. All applications are reviewed on a case-by-case basis and there is no cost to apply.

ELIGIBILITY

You may be eligible for the program if you:

- Are a legal United States resident
- Have a valid prescription from a licensed U.S. healthcare professional for a product made available through the Bausch Health PAP
- Do not have insurance coverage for the prescribed Bausch Health product
- Are being treated as an outpatient
- Meet the pre-defined eligibility requirements and total annual household income requirements

For full eligibility requirements, please visit BauschHealthPAP.com

Participating Bausch Health Pharmaceuticals companies include:

BAUSCH + LOMB | Ortho Dermatologics | Salix PHARMACEUTICALS | BAUSCH Health

APPLICATION INSTRUCTIONS

Patient Instructions:

1. Complete the Patient Information and Insurance Information Sections on page 2.
2. **Read and sign the Patient Authorization and Certification on page 3.**
3. Have your prescriber complete pages 4 and 5 and sign Prescriber Certification on page 5.
4. Attach a copy of your medical and prescription insurance cards (front and back).
   Special note: If a copy of your card is not provided, your application will be incomplete.

Prescriber Instructions:

1. Complete Product Information on page 6.
2. **Sign Prescriber Certification on page 4.**
3. Attach original valid prescription(s) with physician signature. **Stamped signatures are not allowed for controlled substances.**

   Special note: New York prescriber's must submit the patient's prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank, if applicable for your state. **Faxed prescriptions must be faxed from the prescriber's office.**
4. Have patient complete pages 2 and 3.

TO APPLY

Fax or Mail the completed application form, requested documentation, and signed original prescription to:

FAX: 866-777-5705 *Or*

MAIL: BAUSCH HEALTH PATIENT ASSISTANCE PROGRAM
P.O. BOX 6122
LAWRENCEVILLE, NJ 08648

For program questions please contact
BAUSCH HEALTH PATIENT ASSISTANCE – 833-862-8727

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Patient Assistance Program Application

PATIENT INFORMATION (All information note with an * is required information)

*First Name	*Last Name	
*Street Address		
*City	*State	*ZIP Code
*Primary Phone ☐ Home ☐ Mobile	Secondary Phone ☐ Home ☐ Mobile	
*Social Security or Alien ID #	*U.S. Resident ☐ Yes ☐ No	*Gender ☐ Male ☐ Female
Email	*Date of Birth (mm/dd/yy)	
*Check Number of People in Household (include self) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+		
*Annual Household Income $		

By checking yes below, I authorize the Bausch Health Patient Assistance Program (BHPAP) to send text messages to my cell phone to convey important information related to my application status or potential shipments. I understand that standard text messaging rates will apply to any messages received from BHPAP. I also understand that I or BHPAP may revoke this permission in writing at any time. I further agree that in the event my cell phone number changes I will inform the program.

I authorize receiving program communication via text? ☐ Yes ☐ No

INSURANCE INFORMATION (All information note with an * is required information)

☐ ***I Do Not Have Health Insurance or Prescription Coverage** (if checked, go to page 3)

☐ ***Private Insurance** (such as HMO or PPO)	***Does** your policy include Prescription Drug Coverage? ☐ Yes ☐ No	
*Insurer Name	*Insurer Phone	
*Cardholder Name	*Cardholder Date of Birth (mm/dd/yy)	
*Relationship to Cardholder	*Group ID #	
*Policy ID #	*Rx BIN #	*Rx PCN #

☐ ***Medicare** (select all that apply)

***Medicare Part A**? ☐ Yes ☐ No	***Medicare Part B**? ☐ Yes ☐ No	***Medicare Part C** (Medicare Advantage)? ☐ Yes ☐ No
*Insurer Name		
*Insurer Phone	*Medicare Policy ID #	
***Medicare Part D**? ☐ Yes ☐ No **If you received a denial letter for Low Income Subsidy, please attach a copy with your application.**		
*Part D Plan Name	*Group ID #	*Part D Plan Phone
*Part D Policy ID #	*Rx BIN #	*Rx PCN #

☐ ***Other Government Insurance**

*Medicaid? ☐ Yes ☐ No	*Veterans Affairs (VA) Benefits? ☐ Yes ☐ No	
*State Elderly Drug Assistance? ☐ Yes ☐ No	*Other State/Federal Patient Assistance Program? ☐ Yes ☐ No	
*Plan Name	*Phone	
*Policy ID #	*Rx BIN #	*Rx PCN #
*Any other benefit program that helps pay for prescription drugs? ☐ Yes ☐ No		

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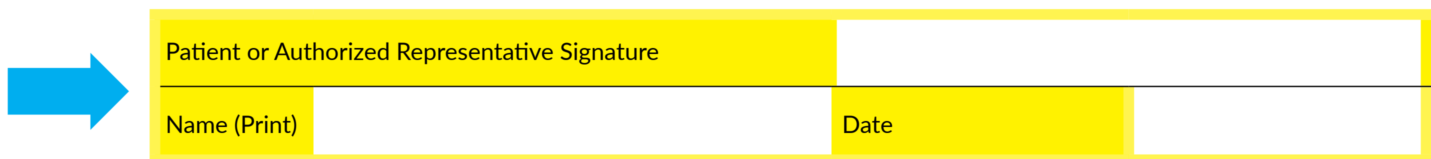
PATIENT AUTHORIZATION and CERTIFICATION (Patient must read and sign below)

I hereby consent to allow Bausch Health Pharmaceuticals, and its affiliates, agents, and contractors, including the administrator of the Bausch Health PAP, the dispensing pharmacy or distributor of Bausch Health products (collectively, "Bausch Health") to use and/or disclose the information in this form and my dispensing information to any third party engaged to assist Bausch Health in the administration of the Bausch Health PAP, including seeking providers of alternate sources of funding for prescription drug costs for Bausch Health products, which may exclude me from participation in the Bausch Health PAP. I understand that this information will be used to determine my eligibility for participation in the Bausch Health PAP and to administer the program, except as may be required or permitted by applicable law, and that Bausch Health reserves the right at any time for any reason to contact me and to request additional information. I, the applicant named below, understand that I am providing 'written instructions' to Bausch Health and its vendor, J. Knipper and Company, Inc., under the Fair Credit Reporting Act authorizing J. Knipper and Company, Inc. on behalf of Bausch Health to obtain information from my credit profile or other information from Experian Health or any other credit reporting agency. I authorize Bausch Health and its partnered provider, J. Knipper and Company, Inc. to obtain such information solely for determining financial qualifications for the Bausch Health PAP. My credit profile or other information received from Experian Health and/or any other credit reporting agency will be used to estimate my household size and household income as part of the process to decide if I am eligible to participate in the Bausch Health PAP. If I am deemed ineligible, and upon my request, Bausch Health will provide me contact information of the credit reporting agency that provided my credit profile and/or other information. I may call the Bausch Health Patient Assistance Program at 1-833-862-8721 for this contact information. I understand that I must affirmatively agree to the terms in this notice by signing below to proceed in the PAP financial screening process. I understand that I am not required to give my consent, and that while my refusal will not impact my health care providers' treatment of me, if I do not provide consent, Bausch Health will not be able to evaluate my eligibility for the Bausch Health PAP. I understand that the information I provide may be subjected to re-disclosure and will no longer be protected by HIPAA. I understand that Bausch Health and any third party engaged to assist in the administration of the program has the right to verify my eligibility, including the right to audit any information provided by me or my physician. I understand that the parties disclosing or receiving my data pursuant to this authorization may receive financial remuneration from Bausch Health. I also understand that Bausch Health has the right to contact me directly by phone, mail, or email, if my email address was supplied on page 1, and to confirm product delivery and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation in the Bausch Health PAP at any time by either calling the Bausch Health PAP at (833-862-8727) or mailing a letter to Bausch Health Patient Assistance Program, P.O. Box 6122, Lawrenceville, NJ 08648.

By signing below, I verify that the information I provide in this application, including all copies of documentation, if applicable, is complete and accurate, and that I am authorized to sign this application. I also verify that I am not currently receiving benefits or coverage for the product(s) selected on page 3 from Medicaid, Medicare, or any other public or private insurance or assistance program. I acknowledge and agree that I shall not report or count the value of any product provided to me under the Bausch Health PAP toward any insurance deductible or, if I am enrolled in Medicare Part D, as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit. In addition, I will not seek reimbursement from any insurance provider or plan, including any Medicare Part B or Medicare Part D plan, for the cost of any free product provided by the Bausch Health PAP and for the remainder of my eligibility period I will continue to receive all of my prescriptions for the selected products from the Bausch Health PAP. I also agree that I will contact Bausch Health if any of the information regarding my prescription drug coverage or insurance changes. I understand that this form expires in one year or when my program eligibility expires.



Patient or Authorized Representative Signature			
Name (Print)		Date	

ALTERNATE/AUTHORIZED PATIENT REPRESENTATIVE (If applicable)

If additional authorized patient representative required, attach information to application with information below.

Complete if Bausch Health PAP may address insurance or other financial questions or other application-related issues with my authorized representative on my behalf.

Patient's Signature	**Date**
Authorized Patient Representative Name	
Relationship to patient	Primary Phone #
Email	

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Patient Assistance Program Application

PRESCRIBER INFORMATION (All information note with an * is required information)

PATIENT NAME

Does the patient have any known allergies (required)? ☐ None Known

Please list the names of other medications the patient is currently taking ☐ None

PRESCRIBER INFORMATION

*First Name	*Last Name	*Designation
*Practice Name		Specialty
*Street Address		
*City	*State	*ZIP Code
*NPI #	*State License #	DEA # Required for controlled substance products
Office Contact Name	Email	
*Phone	*Fax	

SHIPPING INFORMATION (Complete if shipping to prescriber's office and information is different from Prescriber)

Ship to Site/Facility Name	NPI # (if different from above)	
Shipping Address		
City	State	Zip Code
Delivery Contact Name	Phone	

For program questions please contact
BAUSCH HEALTH PATIENT ASSISTANCE – 833-862-8727

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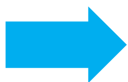
PRESCRIBER CERTIFICATION

I have determined, based on my independent clinical judgment, that the above-named patient should be treated with the Bausch Health product(s) identified on page 3. By signing below, I confirm that the patient is under my care on an outpatient basis; I will not charge the patient any fee for enrollment or other activities associated with the patient's participation in the Bausch Health PAP; I will not charge the patient for any professional services associated with the product(s) that are not covered by the patient's insurance provider or plan, or when the patient's costs associated with the prescribed product(s) represents a financial hardship and assistance has been approved by the Bausch Health PAP; I will not make any claim to any third party payer (e.g., Medicaid, Medicare, public or private insurance, etc.) for payment of product provided by the Bausch Health PAP; I will not sell, trade or return for credit the products(s) provided under the Bausch Health PAP; and I am not prohibited from participating in federally funded health care programs nor am I on the List of Excluded Individuals/ Entities maintained by the HHS Office of Inspector General. To the best of my knowledge, the patient does not have affordable third party insurance coverage for the selected product(s) through, for example, an HMO, private insurance, a State pharmacy program, Medicare, Medicaid, or Veterans Assistance, and the patient meets all other Bausch Health PAP eligibility requirements. By signing this form, I authorize Bausch Health PAP as my designated agent on behalf of the patient, to forward the prescription for the product(s) selected and presented herein by fax or other mode of delivery to the Bausch Health PAP dispensing pharmacy or distributor for fulfillment and/or dispensing. By including my email address on page 3, I agree to receive communication related to Bausch Health PAP by email.



Prescriber's Signature		**Date**	

Physician's signature required. **Stamped signatures are not allowed for controlled substances.** Special note: New York prescriber's must submit the patient's prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank, if applicable for your state. **Faxed prescriptions must be faxed from the prescriber's office.**

Bausch Health Patient Assistance Program benefits, rules, and product availability are subject to change at any time without prior notification.

You are encouraged to report negative side effects of prescription drugs to FDA at **www.fda.gov/Safety/MedWatch**, or call 1-800-FDA-1088.

Please see full Prescribing Information, including any Boxed Warning, Medication Guide and/or Patient Information, available at BauschHealthPAP.com or call Bausch Health Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.

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BAUSCH+ Health

Patient Assistance Program Application

PRODUCT INFORMATION (To be completed by the Prescriber)

Patient Name

Select from product listing below and attach original valid prescription(s) with physician signature. Eligible patients may be able to receive product through this program for up to one year, as long as a valid prescription remains on file. **This is not a prescription.**

SHIP TO (required) ☐ **Patient's Home** ☐ **Prescribing Physician's Office** If no selection is made, the shipment will go directly to the patient.

	BAUSCH + LOMB PRODUCTS
☐	**ALREX**® (loteprednol etabonate ophthalmic suspension) 0.2%
☐	**BEPREVE**® (bepotastine besilate ophthalmic solution) 1.5%
☐	**BESIVANCE**® (besifloxacin ophthalmic suspension) 0.6%
☐	**LACRISERT**® (hydroxypropyl cellulose ophthalmic insert)
☐	**LOTEMAX**® (loteprednol etabonate ophthalmic gel) ☐ 0.38% ☐ 0.5%
☐	**MACUGEN**® (pegaptanib sodium injection) intravitreal injection
☐	**PROLENSA**® (bromfenac ophthalmic solution) 0.07%
☐	**RETISERT**® (fluocinolone acetonide intravitreal implant) 0.59 mg for intravitreal use
☐	**TIMOPTIC**® in OCUDOSE® (timolol maleate ophthalmic solution) ☐ 0.25% ☐ 0.5%
☐	**VISUDYNE**® (verteporfin for injection), for intravenous use
☐	**VYZULTA**™ (latanoprostene bunod ophthalmic solution) 0.024%
☐	**ZIRGAN**® (ganciclovir ophthalmic gel) 0.15%
☐	**ZYLET**® (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension)

	BAUSCH HEALTH PHARMACEUTICALS PRODUCTS
☐	**ANCOBON**® (flucytosine) 500 mg Capsules
☐	**ANDROID**® (C-III) (methylTESTOSTERone Capsules, USP), 10 mg
☐	**CUPRIMINE**® (penicillamine) Capsules
☐	**DEMSER**® (metyrosine) Capsules
☐	**LODOSYN**® (carbidopa) tablets
☐	**MEPHYTON**® (phytonadione) Vitamin K1 tablets
☐	**OXSORALEN-ULTRA**® Capsules (methoxsalen capsules, USP, 10 mg)
☐	**SYPRINE**® (trientine hydrochloride) capsules
☐	**TARGRETIN**® (bexarotene) capsules, for oral use
☐	**TARGRETIN**® (bexarotene) Gel 1%
☐	***TASMAR***® (tolcapone) Tablets
☐	**ZELAPAR**® (selegiline hydrochloride) Orally Disintegrating Tablets

	SALIX PHARMACEUTICALS PRODUCTS
☐	**APRISO**® (mesalamine) extended-release capsules
☐	**CYCLOSET**® (bromocriptine mesylate tablets), for oral use
☐	**MOVIPREP**® (polyethylene glycol 3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate, and ascorbic acid for oral solution)
☐	**RELISTOR**® (methylnaltrexone bromide) tablets, for oral use, 90-count
☐	**RELISTOR**® (methylnaltrexone bromide) injection, for subcutaneous use (7 single-dose pre-filled syringes per carton) ☐ 8 mg/0.4 mL ☐ 12 mg/0.6 mL
☐	**UCERIS**® (budesonide) rectal foam
☐	**XIFAXAN**® (rifaximin) Tablets, for oral use, 550 mg

	ORTHO DERMATOLOGICS PRODUCTS
☐	**ACANYA**® (clindamycin phosphate and benzoyl peroxide) Gel, ☐ 1.2% ☐ 2.5%, for topical use
☐	**ALDARA**® Cream 5%
☐	**ATOPICLAIR**® Nonsteroidal Cream 100 g Tube
☐	**BENZAMYCIN GEL**® 46.6 g
☐	**BIAFINE**® 45 g Trade
☐	**BRYHALI**™ (halobetasol propionate) Lotion, 0.01% ☐ 60 g ☐ 100 g
☐	**CARAC**® (fluorouracil cream) Cream, 0.5%
☐	**CLINDAGEL**® (clindamycin phosphate gel) topical gel, 1%
☐	**EFUDEX**®
☐	**ELIDEL**® (pimecrolimus) Cream, 1% for topical use
☐	**HYLATOPIC PLUS LOTION**® 14 oz Bottle
☐	**HYLATOPIC PLUS FOAM**® 100 g Canister
☐	**HYLATOPIC PLUS CREAM**® 100 g Tube
☐	**JUBLIA**® (efinaconazole) topical solution, 10% ☐ 4 mL ☐ 8 mL
☐	**LOCOID LIPOCREAM**® Cream 45 g
☐	**LOCOID**® (hydrocortisone butyrate) Lotion, 0.1%, for topical use
☐	**LUZU**® (luliconazole) Cream, 1% for topical use
☐	**NORITATE**® (metronidazole cream) Cream, 1% for topical use only
☐	**ONEXTON**® (clindamycin phosphate and benzoyl peroxide) Gel, ☐ 1.2% ☐ 3.75% for topical use
☐	**RENOVA**® (tretinoin cream) 0.02% for topical use, pump
☐	**RETIN-A CREAM**® 45 gm ☐ 0.025% ☐ 0.05% ☐ 0.1%
☐	**RETIN-A GEL**® 45 gm ☐ 0.01% ☐ 0.025%
☐	**RETIN-A MICRO**® (tretinoin) Gel microsphere for topical use ☐ 0.06% ☐ 0.08%
☐	**SOLODYN**® (minocycline HCl) extended release tablets for oral use ☐ 55 mg ☐ 80 mg ☐ 105 mg
☐	**TARGRETIN**® (bexarotene) capsules, for oral use
☐	**TARGRETIN**® (bexarotene) Gel 1%
☐	**TETRIX CREAM**® 90 g Tube
☐	**ZYCLARA**® (imiquimod) cream 3.75%, for topical use 7.5 g pump box of 28 packets

Before prescribing any product on the above list, please see full Prescribing Information, including any Boxed Warning, Medication Guide, and/or Patient Information, available at BauschHealthPAP.com or call Bausch Health Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.

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