BAUSCH Health Provisional Application for Medicaid-Only Patients

Thank you for your interest in the Bausch Health Patient Assistance Program (Bausch Health PAP).
This application is for patients who are insured exclusively by Medicaid plans and whose pharmacy benefit does not provide coverage for the relevant Bausch Health product(s).

ELIGIBILITY

For full eligibility requirements, please visit BauschHealthPAP.com

TO APPLY

Fax or Mail the completed application form and any requested documentation to:

FAX: 844-705-0160 ***Or***

MAIL: BAUSCH HEALTH PATIENT ASSISTANCE PROGRAM
P.O. Box 991624
Louisville, KY 40269

KnippeRx Pharmacy can be located within your EMR/EHR system under the following credentials

PHARMACY INFORMATION						
KnippeRx Pharmacy						
<Address>	1250 Patrol Rd Suite 100					
	<City>	Charlestown	**<State>**	IN	**<Zip>**	47111
<Office Phone>	855-647-7379		**<Office Fax>**	855-774-3879		
Pharmacy Identifiers	**NPI 1285159152**		**NABP 1568560**		**DEA FK7013927**	

Please note in the comments that this eRx is for a Medicaid Applicant.

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

*First Name		*Last Name	
*Street Address			
*City		*State	*ZIP Code
*Primary Phone ☐ Home ☐ Mobile		Email	

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. By checking Yes here I am authorizing program communications to be received via text. ☐ Yes ☐ No

*Last 4 digits of the Social Security Number		*U.S. Resident ☐ Yes ☐ No	*Gender ☐ Male ☐ Female
If you do not have an SSN, please attach other documentation showing proof of legal US residency.		*Date of Birth (mm/dd/yy)	

MEDICAID INFORMATION (All information noted with an * is required information)

*Medicaid State	*Medicaid Plan Name	
*Coverage Start Date	*Coverage End Date	
*Policy ID #	*Rx BIN #	*Rx PCN #
*Any other benefit program that helps pay for prescription drugs? ☐ Yes ☐ No		

*ALLERGIES: ☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Penicillin ☐ Sulfa Other

*MEDICAL CONDITIONS: ☐ None ☐ Asthma ☐ Glaucoma ☐ Heart ☐ High BP ☐ Ulcer Other

*CURRENT MEDICATION(S) BEING TAKEN BY THE PATIENT:

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

PATIENT AUTHORIZATION FOR USE and DISCLOSURE of PERSONAL HEALTH INFORMATION (Patient must read and sign below)

I hereby consent to allow and authorize Bausch Health Companies Inc., and its affiliates, agents, and contractors, including the administrator of the Bausch Health Patient Assistance Program ("Bausch Health PAP"), and the dispensing pharmacy or distributor of Bausch Health products (collectively, "Bausch Health") to use and/or disclose my personal health information ("PHI") including 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, and my participation in the program, and that Bausch Health reserves the right at any time for any reason to contact me and to request additional information. I authorize my physician, pharmacy and my health plan(s) and individuals affiliated with them to disclose my PHI including information related to my condition and information on this application form. I authorize Bausch Health to contact any of these persons or entities on my behalf in order to collect my PHI or any other personal information necessary to complete this application or to determine if I am eligible for benefits under the Bausch Health PAP. I understand that my PHI disclosed in this application or in relation to this application may no longer be protected by any privacy laws and may be re-disclosed by Bausch Health for the purposes described here. I understand that I am not required to give my consent or authorization, 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.

APPLICANT CERTIFICATION (Patient must read and sign below)

By signing below, I certify that the information provided in this application, including all copies of documentation, if applicable, is complete and accurate, and that I am authorized to sign this application. I understand that benefits under the Bausch Health PAP will terminate if the program determines that any of the information supplied was not truthful or accurate. I understand that completing this application does not ensure that I will quality for the Bausch Health PAP. 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 or submit claims to any insurance provider or plan, including Medicare Parts B or D, or Medicaid, for the costs of any free product provided by the Bausch Health PAP. For the remainder of my eligibility period I will continue to receive all 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 Bausch Health and any third party engaged to assist in the administration of the Bausch Health PAP 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 Bausch Health reserves the right to modify or discontinue the program or terminate any benefits I receive at any time and without notice. I authorize Bausch Health to forward the prescription associated with this application to a dispensing pharmacy on my behalf. I understand that the Bausch Health PAP is not insurance.

SIGN Applicant's Signature _____ Date _____

ALTERNATE/AUTHORIZED PATIENT REPRESENTATIVE (If applicable)

If an additional authorized patient representative is required, attach additional information to this application with the 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	Fax #	Primary Phone #
Email		

BAUSCH Health Provisional Application for Medicaid-Only Patients

PRODUCT INFORMATION (To be completed by the Prescriber)

Patient Name	*Date of Birth (mm/dd/yy)

Select from product listing below. Eligible patients may be able to receive product through this program for up to one year, up to a 90 day supply per dispense, as long as a valid prescription remains on file.

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

BAUSCH HEALTH PHARMACEUTICALS PRODUCTS

☐	**APLENZIN®** (bupropion hydrobromide), Extended-Release Tablets, ☐ 174 mg ☐ 348 mg ☐ 522 mg
☐	**CUPRIMINE®** (penicillamine) 250 mg Capsules
☐	**DEMSER®** (metyrosine) 250 mg Capsules
☐	**SYPRINE®** (trientine hydrochloride) 250 mg Capsules
☐	**TASMAR®** (tolcapone) 100 mg Tablets
☐	**ZELAPAR®** (selegiline hydrochloride) 1.25 mg Orally Disintegrating Tablets

SALIX PHARMACEUTICALS PRODUCTS

☐	**XIFAXAN®** (rifaximin) Tablets, for Oral Use, 550 mg
☐	**RELISTOR®** (methylnaltrexone bromide) 150 mg 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
☐	**TRULANCE®** (plecanatide) 3 mg Tablets
☐	**UCERIS®** (budesonide) 2 mg Rectal Foam

ORTHO DERMATOLOGICS PRODUCTS

☐	**ARAZLO®** (tazarotene) Lotion, 0.045%
☐	**BRYHALI®** (halobetasol propionate) Lotion, 0.01% ☐ 60 g ☐ 100 g for Topical Use
☐	**DUOBRII®** (halobetasol propionate and tazarotene 0.01%/0.45%) 100 g for Topical Use
☐	**JUBLIA®** (efinaconazole) Topical Solution, 10% ☐ 4 mL ☐ 8 mL
☐	**LUZU®** (luliconazole) Cream, 1% for Topical Use
☐	**NORITATE®** (metronidazole cream) Cream, 1% for Topical Use Only
☐	**SILIQ®** (brodalumab) Injection 210mg/1.5mL (1 box of 2 syringes)
☐	**TARGRETIN®** (bexarotene) 75 mg Capsules, for Oral Use
☐	**TARGRETIN®** (bexarotene) Gel 1%

INFORMATION FOR THE PHARMACY TO TRANSFER OR THE HCP TO E-PRESCRIBE OR FAX A PRESCRIPTION (All information noted with an * is required information)

*Pharmacy currently fullfilling			
*Address			
*City	*State	*ZIP Code	
*Phone	Email		

HCP INFORMATION (All information noted with an * is required information)

*HCP Name		NPI	
*Address			
*City	*State	*ZIP Code	
*Phone	Fax		

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.

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