



A Public Service Foundation of the
American Academy of Ophthalmology

**Directory of
Ophthalmic
Pharmaceutical
Assistance Programs**

for the
Medically
Underserved

*A resource guide listing ophthalmic drugs and systemic medication for use
by physicians and health professions who help prevent vision loss among
the medically underserved*

2003

Foreward

This directory was created by the EyeCare America, a public service foundation of the American Academy of Ophthalmology, for the exclusive use of physicians to help them obtain ophthalmic drugs for their needy patients. The companies listed are not affiliated with EyeCare America or the American Academy of Ophthalmology nor does their inclusion imply endorsement of their products. The pharmaceutical companies included in this directory decided which medications to list. Each company listed in this booklet reserves the right to modify or discontinue their program at any time for any reason. The following listing is by no means exhaustive, and we invite additional organizations to participate in future listings. The information has been prepared with great care, but we cannot guarantee it to be complete or correct in all cases.

Acknowledgments

EyeCare America would like to thank the companies who have agreed to be listed in this directory. Appreciation is also extended to Robin D. Ross, MD, and Tracey Utley, COT, who surveyed pharmaceutical company programs and provided the information which led to the formation of this document.

EyeCare America Committed to the Preservation of Sight

Founded in 1980, EyeCare America, a public service foundation of the American Academy of Ophthalmology, is committed to the preservation of sight, accomplishing its mission through public service and education. In the United States, EyeCare America is one of the largest providers of eye care services to the medically underserved and educates the general public about the eye and vision. In developing nations, EyeCare America helps improve eye care by providing free educational resources and materials to ophthalmologists in those nations. EyeCare America is a non-profit organization whose success is made possible by its corps of more than 7,500 volunteer ophthalmologists who donate their services.

EyeCare America's public service program provides access to eye care for the medically underserved and for those at increased risk for eye disease. More than 90 percent of the care made available through EyeCare America is provided with no out-of-pocket cost to the patients. Public service includes programs for seniors, glaucoma, diabetes, and children, and is the largest program of its kind in the United States. Since its inception, EyeCare America's public service program has handled more than 644,000 calls, provided services to 347,000 people, and treated more than 180,000 cases of eye disease. EyeCare America operates multiple programs for which callers may be eligible.

The Seniors EyeCare Program ensures that every senior has access to medical eye care and promotes annual, dilated eye exams. It raises awareness about age-related eye disease, including cataracts, provides free eye care educational materials and facilitates access to eye care.

Seniors may call the toll-free helpline at 800-222-EYES (3937) anytime, for themselves, their family members or friends to see if they qualify to receive a referral to a volunteer ophthalmologist. Eligible seniors receive a comprehensive, medical eye exam and up to one year of treatment for any disease diagnosed during the initial exam, often at no out-of-pocket cost.

The Seniors EyeCare Program is designed for people who:

- Are US citizens or legal residents
- Are age 65 and older
- Have not seen an ophthalmologist in three or more years
- Do not have eye care insurance through an HMO or the VA

The Glaucoma EyeCare Program encourages early detection and treatment of glaucoma by promoting awareness of glaucoma risk factors and providing glaucoma eye exams to qualified individuals who are at increased risk. Individuals who call the toll-free helpline are screened for evidenced-based risk factors, including family history, race and age. Those found to be at increased risk for glaucoma may qualify to receive a glaucoma eye examination by a volunteer ophthalmologist in their area.

The Diabetes EyeCare Program provides educational materials that increase awareness of the importance of yearly, dilated eye examinations for individuals 65 and older with diabetes. Eligible seniors with diabetes receive a comprehensive, medical eye exam and up to one year of treatment for any disease diagnosed during the initial exam, often at no out-of-pocket cost.

Children's EyeCare Program educates parent and primary care physicians about the importance of early childhood eye screenings and treatment. Free brochures are available on the EyeCare America website www.eyecareamerica.org.

To enroll as an ECA volunteer ophthalmologist, please call the ECA administrative toll-free number, 877-887-6327.

Funding for EyeCare America is provided by donations from corporations, foundations, and individuals. The Seniors EyeCare Program is co-sponsored by the Knights Templar Eye Foundation.

General Guidelines:

1. Patients must be considered “medically needy” by a physician.
2. Patients must not be eligible for third party coverage (Medicare, Medicaid, Private Insurance).
3. Pharmaceutical company information forms must be completed and signed by a physician.
4. Renewal of paperwork may be required at intervals.
5. Some companies require financial information and verification (Tax form or W2).
6. Original prescription(s) with DEA # may be required.
7. Many companies now require original doctor signature—no stamps.
8. Medications are shipped to the physician’s office for delivery to the patient. Individual companies may have other requirements.
9. We have made an effort to include some systemic medications supplied by the companies which can affect your patient’s vision (Myasthenia, CMV retinitis, Diabetes, Uveitis, etc.).
10. Each company listed in this booklet reserves the right to modify or discontinue their program at any time for any reason.

For More Information and for Web Based Updates:

1. Check out: www.needymeds.com
2. Apply online at: www.RxHope.com
3. Visit the pharmaceutical research web site: www.phrma.org
4. Write to:
The Pharmaceutical Research
and Manufacturers of America
1100 Fifteenth Street NW
Washington, DC 20005

For an additional copy of this publication, please contact:
Public Service Programs
EyeCare America
PO Box 429098
San Francisco, CA 94142-9098

Telephone: 877-887-6327
Visit our websight at www.eyecareamerica.org

AKORN

Program Name: No official program

Address: *Physician Requests Should Be Directed To:*
2500 Millbrook Dr.
Buffalo Grove, IL 60089-4694

Phone: 800-535-7155

Fax: 847-279-6123

Web: www.akorn.com

Eligibility: Evaluated on a case by case basis

Medications: Any drug the company manufactures

AKBETA
AK-CIDE
AK-CIDE ointment
AK-CON
AK-DEX
AK-DILATE 2.5% and 10%
AK-FLUOR Injection 10% and 25%
AK-NEFRIN
AK-NEO-DEX
AK-PENTOLATE
AK-POLY-BAC ointment
AK-PRED
AK-Rinse
AK-SPORE HC Ointment
AK-SULF
AK-TAINE
AK-TOB
AK-TRACIN Ointment
AK-TROL ointment and suspension

Contact: Chris Vogel

ALCON LABORATORIES (includes Falcon)

Program Name: **Alcon Glaucoma Patient Assistance Program**

Address: *Physician Requests Should Be Directed To:*
Alcon Laboratories, Inc.
Humanitarian Services
Dept. T7-18
6201 S. Freeway
Fort Worth, TX 76134-2099

Phone: 800-222-8103 option 2
800-451-3937 x8719
GPAP applications should be faxed with an RX to:

Fax: 817-568-7000

Email: cheryl.dailey@alconlabs.com

Eligibility: 1. Private patient
2. Deemed medically needy by practicing eye care specialist
3. Ineligible for local, state, or federal prescription reimbursement programs and is deemed truly needy by the doctor

Requirements: 1. Complete application with RX of the medication requested
2. Include doctor's name, original signature, state license number, DEA number, patient's name, quantity and concentration of each medication requested.
3. May fax application and RX to above number

Medications: Azopt 1% (4 ea., 15 ml)
Betoptic S 0.25% (4 ea., 15 ml)
Iopidine 0.5% (4 ea., 10 ml)
Isopto Carpine 1% (6 ea., 15 ml)
Isopto Carpine 2% (6 ea., 15 ml)
Isopto Carpine 4% (6 ea., 15 ml)
Isopto Carpine 6% (6 ea., 15 ml)
Isopto Carbachol 0.75% (6 ea., 15 ml)
Isopto Carbachol 1.5%, (6 ea., 15 ml)
Isopto Carbachol 3% (6 ea., 30 ml)
Pilopine HS Gel 4% (4 ea., 4.0 gm tubes)
Travatan 0.004% Ophth Sol (6 ea., 2.5ml)

Falcon Products

Carteolol HCL Opth Sol 1% (4 ea., 10ml)
Dipivefrin HCL Opth Sol 0.1% (4 ea., 15ml)
Levobunolol HCL Opth Sol 0.5% (4 ea., 15ml)
Metipanolol Sol 0.3% (4ea., 10 ml)
Timolol Maleate Gel forming 0.25% (4 ea., 5ml)
Timolol Maleate Gel forming 0.50% (4 ea., 5ml)
Timolol Maleate Opth Sol 0.25% (4 ea., 15ml)
Timolol Maleate Opth Sol 0.50% (4 ea., 15ml)

Turnover: Three weeks

Duration: Set amount (see above quantity) sent each time
Must reapply each time with an RX per application

Contact: Cheryl Dailey
Program Coordinator, Glaucoma Patient Assistance Program

ALCON LABORATORIES (includes Falcon)

Program Name: **Medical Need Program**

Address: *Physician Requests Should Be Directed To:*
Alcon Laboratories, Inc.
Humanitarian Services
Dept. T7-18
6201 S. Freeway
Fort Worth, TX 76134-2099

Phone: 800-222-8103 option 2
800-451-3937 x8719
Medical Need Request applications should be faxed with an RX to:

Fax: 817-615-5333

Email: Kim.brown@alconlabs.com

Eligibility: 1. Private patient
2. Deemed medically needy by practicing eye care specialist
3. Ineligible for local, state, or federal prescription reimbursement programs and is deemed truly needy by the doctor

Requirements: 1. Complete application with RX of the medication requested
2. Include doctor's name, original signature, state license number, DEA number, patient's name, quantity and concentration of each medication requested.
3. May fax application and RX to above number

Medications: Ciloxan Ointment
Ciloxan Solution
Cipro HC Otic
Ciprodex Otic
Econopred Plus
Flarex
Maxitrol Ointment
Maxitrol Solution
Tobradex Solution
Tobradex Ointment
Vexol
Vigamox

OTC Medications:

A maximum of 6 months supply per year will be provided

Bion Tears

Systane

Tears Natural Forte

Tears Natural FREE

TN PM Eye Ointment

Unisol 4 Saline

Turnover: Two weeks

Duration: Quantities based on long term/short term use as indicated on application

Contact: Kim Brown—Program Coordinator, Medical Need Program

ALLERGAN

Program: **Allergan Patient Assistance Program**

Address: *Physician Requests Should Be Directed To:*
Allergan Patient Assistance Program
PO Box 1003
Wayne, NJ 07474-9928

Phone: 800-347-4500 x7791

Web: www.allergan.com/profpath/healthcareprofessional.htm

Eligibility: 1. Deemed medically indigent by physician
2. Ineligible for third party reimbursement
3. Patient's annual household income must not exceed \$12,000 for one or two person household or \$19,000 for three or more persons

Requirements: 1. Complete Allergan Information form
2. Include dosing frequency with all artificial tear products
3. Physician original signature

Medications:	Alphagan P 0.2%	(3 ea., 15 ml; 3 bottles)
	Betagan 0.25%	(4 ea., 10 ml; 4 bottles)
	Betagan 0.5% BID	(3 ea., 15 ml; 3 bottles)
	Celluvisc	(30 CT.; #48)
	Lumigan 0.03%	(3 ea., 5ml; 3 bottles)
	Propine 0.1% BID	(3 ea., 15 ml; 3 bottles)
	Refresh Plus	(30 CT.; #48)
	Refresh PM	(3.5G; #24)

Duration: 1. Six month supply
2. At the end of six months, paperwork form needs to be resubmitted

Turnover: 30 days

Contact: Michael Yu—ext. 6762

AMGEN CORP

Program: **Amgen Safety Net Program**

Address: *Physician Requests Should Be Directed To:*
Amgen Safety Net Program
PO Box 13185
La Jolla, CA 92039-3185

Phone: 800-272-9376

Fax: 888-508-8090

Web: www.amgen.com

Eligibility:

1. Provider must be the sponsor for the patient
2. Ineligible for third party reimbursement and lacks prescription coverage
3. Financially unable to afford medication (general, household income less than \$50,000 annually)
4. Dialysis patient (if not a dialysis patient, see PROCRIline program sponsored by OrthoBiotech)

Requirements:

1. Dialysis center, physician, hospital, home health care company must sponsor patient
2. Completion of form (ok to fax copy then mail hard copy)
3. No verification of anemia required
4. Patients must reside within the US or its territories

Medications: Aranesp, Epogen, Neulasta, and Neupogen

Duration: One month

Refill: Reapply annually

Other: Product replacement program (replaces product within 30 days)

ASTRAZENECA PHARMACEUTICALS

Program Name: **AstraZeneca Foundation Patient Assistance Program**

Address: *Physician Requests Should Be Directed To:*
AstraZeneca Foundation Patient Assistance Program
1800 Concord Pike
Wilmington, DE 19850

Phone: 800-424-3727 (automated #)
800-456-3669

Fax: 302-886-2972

Office hours: Monday-Friday, 9AM-5PM (Eastern Standard Time)

Medication: Foscavir (foscarnet sodium) for intravenous injection

Eligibility: 1. Case by case
2. US citizen

Requirements: 1. Provider or contact person must call
2. Complete initial form (patient name, date of birth, diagnosis)
3. Signed prescription by a physician
4. Medication sent to physician's office each month
5. Contact by phone or fax each month for monthly request

Recommendations:
1. Call a request in by phone
2. Application sent to physician within 24 hours
3. F.A.I.R analyzes your patient's insurance coverage options
4. Turnover is as fast as 48 hours (shipped federal express)
5. Fax accepted but hard copy paperwork still required via mail every 12 months reapply

Refill: Every six months

Contact: None. Staff of 6 analysts

BAUSCH & LOMB PHARMACEUTICALS, INC.

Program Name: **Indigent Patient Program**

Address: *Physician Requests Should Be Directed To*
Bausch & Lomb Pharmaceuticals, Inc.
Indigent Patient Program
PO Box 30450
Rochester , NY 14603-0450

Phone: 800-323-0000 (8 am-5pm EST)

Fax: 813-975-7762

Eligibility: Financially needy: annual household income of less than \$9000 for one person or a combined family income of no more than \$14,000 annually

Requirements: 1. Complete B& L application
2. Physician's original signature
3. Requests accepted once per calendar quarter per patient
4. Completed prescription attached to every application
5. No fax, must be mailed

Medications: Alrex 0.2% (maximum 3 ea., 5 ml)
Lotemax 0.5% (maximum 3 ea., 5 ml)

Supply: 3 bottles of any product on any one request

Turnover: Allow 4-6 weeks for delivery

Other: Any request above the maximum limit will not be shipped

Refill: Reapply every 3 months

BRISTOL-MYERS SQUIBB

Program Name: **Bristol Myers Squibb Patient Assistance Foundation, Inc,**

Address: Bristol Myers Squibb Patient Assistance Foundation, Inc,
PO Box 52112
Phoenix, AZ 85072-2112

Phone: 800-736-0003 (9am-6pm EST)

Fax: 800-736-1611
DO NOT fax multiple submissions

Web:

- Eligibility:
1. US citizen or legal resident alien
 2. Financially needy, based on monthly income
 3. Determined within 7-10 business days

- Requirements:
1. Complete application
 2. RX instruction portion of application be completed in full:
Drug name, strength, quantity per day, and NDC # (see Drug list)
 3. Prescriptions unnecessary

Ophthalmic

Medications: Kenalog 40, 1 ml vial, vial 40 mg/ml
Kenalog 40, 10 ml vial, vial 40 mg/ml
Kenalog 40, 5 ml vial, vial 40 mg/ml
Kenalog 10, 5 ml vial, vial 10 mg/ml

Other with ophthalmic use:

Avalide, Avapro, Buspar, Cefzil, Coumadin, Desyrel, Dovonex K-lyte, Glucophage, Glucophage XR, Glucovance, Kenalog aerosol, Kenalog cream, Kenalog lotion, Kenalog ointment, Kenalog oral paste, Klotrix, Lac-Hydrin, Lodosyn, Metaglip, Monopril, Mycalog cream, Mycalog ointment, Mycostatin, Naturetin, Plavix, Pravachol, Prolixin, Pronestyl, Serzone, Sinemet, Tequin, Ultravate cream, Ultravate ointment, Vasodilan

CIBA VISION SURGICAL BUSINESS UNIT (A Novartis Company)

Program Name: **Indigent Patient Program for IOL's**

Address: Indigent Patient Program for IOL's
11460 Johns Creek Parkway
Duluth, GA 30097

Phone: 800-233-9223 x4008

Eligibility:

1. Patient must be indigent
2. Patient must not be covered by health insurance or third party payment

Requirements:

1. Physician must call Susan Szcsey and state that the patient is indigent and has no health insurance coverage.
2. Physician should specify the power and type of IOL desired.

Covered Item: Intraocular lenses

Turnover: 4-6 weeks

Contact: Susan Szcsey

CRIXIVAN (A Program of Merck & Co., Inc.)

Program Name: **Support Program**

Address: *Physician Requests Should Be Directed To:*
Support Program
PO Box 222137
Charlotte, NC 28222-2137

Phone: 800-850-3430 (9am-8pm EST)
Dial (1)=English; (2)=Spanish

Fax: 704-357-0036

Web: www.crixivan.com

Eligibility:

1. Patient must reside in the United States
2. No medical insurance with prescription drug coverage (some exceptions may apply)
3. Income guidelines are significantly above the federal poverty guidelines

Requirements:

1. Both physician and patient must complete respective portions of application form
2. Original prescription

Medication: Crixivan

Supply: 90 day supply

Dispensed: Medication sent to doctor's office by 2 day FedEx

Exceptions: Social workers can complete forms in addition to physicians

Other:

1. Each state has a client manager who coordinates qualification into the program. All patients are reviewed on a case-by-case basis for qualification into the program
2. Verification of continuing need for the medication if confirmed every 4-6 weeks by phone or fax or mail
3. Paperwork is resubmitted every year

CYNACON OCUSOFT

Program Name: **None**

Address: PO Box 429
Richmond, TX 77406-0429

Phone: 800-233-5469

Fax: 281-232-6051

Email: www.ocusoft.com

Eligibility: 1. Deemed medically needy by physician

Medication: Lid scrubs

Contact: Rosemary Martinez
Vice President of Sales Operations

ELI LILLY

Program Name: **Lilly Cares**

Address: *Physician Requests Should Be Directed To:*
Lilly Cares
Temporary Patient Assistance Program
PO Box 230999
Centreville, VA 20120

Phone: 800-545-6962

Web: www.lilly.com

Eligibility:

1. Deemed medically and financially needy by physician
2. Nonmedicare patients with no prescription drug coverage
3. A US resident
4. Hospitalized patients are ineligible
5. Medicare patients see Lilly Answers discount program

Requirements:

1. Completion of application (original signatures only)
2. DEA number of physician
3. Application must be mailed
4. Patient must provide proof of gross monthly income and assets and supply amount of out-of-pocket monthly medical expenses

Other Medications with Ophthalmic use:

Glucagon emergency kit, Humalog, Humalog 75/25, Humulin (all types)

Other: Aventyl, Ceclor, Evista, Prozac, Quinidine, ReoPro, Strattera

Turnover: Medication mailed to doctor's office within 1-2 weeks

Duration:

1. Every three months
2. After three months, if financial need still exists, the physician completes another form

Other:

1. Patients needing insulin receive a voucher good for 4 months supply at Pharmacy (no co-pay)
2. A blank application can be photocopied; however, original signatures and information required with each renewal application

GENENTECH, INC.

Program Name: **Genentech Access To Care Foundation**

Address: *Physician Requests Should Be Directed To:*
Genentech Access to Care Foundation
1 DNA Way (Mail Stop 13A)
South San Francisco, CA 94083-2586

Phone: 800-879-4747
800-530-3083

Fax: 650-225-1366

Web: www.gene.com
www.growthhormone.gene.com
www.genentechCFendowment.org

Eligibility: 1. Deemed medically needy by physician
2. Eligibility determined after application form (one page) reviewed as well as copy of latest federal IRS tax return
3. Preliminary information should be faxed

Requirements: 1. Patient must provide detailed financial information to insure the company that they are uninsured and cannot afford the medication (latest federal IRS tax return, including W2's)

Medication: Activase (tissue plasminogen activator)

Other Medications:

TNKase,
Nutropin AQ, Nutropin, Protropin (Growth hormone replacement),
Pulmozyme Inhalation Solution (Cystic Fibrosis treatment),
Rituxan (Antibody treatment in B-cell non-Hodgkin's Lymphoma)
Herceptin (Metastatic Breast Cancer)
Xolair

Other: Shipments made to hospital pharmacy or physician's office

GlaxoSmithKline

Program Name: **GlaxoSmithKline Bridges to Access Program**

Address: Bridges to Access
PO Box 29038
Phoenix, AR 85038-9038

Phone: 866-PATIENT (728-4368)—[8-8pm EST]

Fax: 800-750-9832

Web: www.bridgestoaccess.gsk.com

- Eligibility:
1. The patient must be a resident of the United States
 2. The patient must live in a single person household with an income of not more than \$25,000 per year or a multi-person household with total incomes not totaling more than 250% of the federal poverty level; and
 3. The patient must not be eligible for prescription drug benefits through any private or public insurer/payer program

- Requirements:
1. Designate a patient advocate (i.e , the contact person for the patient--any healthcare worker involved in the patient's care such as a physician, nurse, social worker or someone in the healthcare office)
 2. Advocate obtains enrollment form from web, phone, or fax
 3. Advocate calls Bridges to Access to determine patient eligibility

- Enrollment:
1. Initial phone call will determine patient eligibility
 2. If approved, patient will take coupon with a RX to any retail pharmacy to receive 60-day supply of prescribed medication for \$5 co-pay per drug per fill
 3. Advocate mails enrollment form and appropriate documentation with prescription to Bridges to Access so patient receives refills
 4. If patient remains active, the patient must call toll free number two weeks before the first 90-day supply is finished.

Duration: 90-day supply

Refill: Patient is eligible to participate for 6 months and this can be extended to 12 months before the patient must re-apply for assistance

Ophthalmic

Medications: Daraprim, Valtrex, Zofran, Zofran ODT, Zovirax capsules, Zovirax suspension, Zovirax tablets

Medications: Agenerase solution, Agenerase tablets, Avandia, Avandamet, Combivir, Efavirenz oral suspension, Efavirenz tablets, Immitrex tablets, Immitrex injectables, Immitrex nasal spray, Retrovir capsules, Retrovir syrup, Retrovir tablets, Trizivir, Ziagen oral solution, Ziagen tablets,

Other: Aclovate cream, Aclovate ointment, Advair, Amoxicillin, Augmentin, Avodart, Bactroban, Beconase, Compazine, Coreg, Cutivate, Dexadren capsules, Dexadren tablets, Dyazide, Eskalith CR capsules, Eskalith CR tablets, Flonase, Flovent, Fortaz, Lamictal, Lanoxicaps, Lanoxin, Lotronex, Malarone, Mepron, Oxistat Cream, Oxistat lotion, Parnate, Paxil, Paxil CR, Relafen, Relenza, Requip, Serevent, Stelazine, Tagamet, Temovate, Timentin, Ventolin, Wellbutrin tablets, Wellbutrin SR tablets, Zantac, Zinacef, Zyban

Refill: 3 months

GlaxoSmithKline

Program Name: **GlaxoSmithKline Commitment to Access**

Address: *Physician Requests Should Be Directed To:*
GlaxoSmithKline Commitment to Access
PO Box 29038
Phoenix, AZ 85038-9038

Phone: 866-265-6491 (8am-8pm EST)
8-ONCOLOGY

Eligibility:

1. The patient must be a resident of the United States
2. The patient must live in a household with income of not more than 350% of the federal poverty level, adjusted by household size; and
3. The patient must not be eligible for prescription drug benefits through any private or public insurer/payer program

Web: www.commitmentoaccess.gsk.com

Requirements:

1. Designate a patient advocate (i.e., the contact person for the patient—any healthcare worker involved in the patient’s care such as a physician, nurse, social worker or someone in the healthcare office)
2. Advocate obtains enrollment form from web, phone, or fax

Enrollment:

1. Advocate calls Commitment to Access to determine patient eligibility
2. Advocate faxes the patient prescription for a 30-day supply of medication
3. Patient is authorized to receive 60-day supply of medication in 30-day increments. Medicine is directly shipped to the prescriber.
4. Advocate mails enrollment form with appropriate documentation to Commitment to Access within 20 days of phone call

Supply:

1. Patient eligible for as many as six additional 30-day supplies once enrollment form is obtained.
2. To have 2nd and subsequent 30-day supplies shipped, Advocate must call 1-8-ONCOLOGY five to seven business days before the medication is needed.

Medications With Ophthalmic Use:

Leukeran (chlorambucil), Myleran (busulfan), Zofran oral solution,
Zofran tablets, Zofran ODT

Other Medications:

Hycamtin, Navelbine, Purinethol, Tabloid

MERCK AND CO., INC.

Program Name: **Merck Patient Assistance Program (PAT)**

Address: *Physician Requests Should Be Directed To:*
Merck Patient Assistance Program
PO Box 690
Horsham, PA 19044-9979

Phone: 800-994-2111 (computer based)
800-727-5400 (Questions, contact Merck National Service Center)

Eligibility: 1. The patient's income must be below \$18,000 for an individual and below \$24,000 for a couple
2. Patient must be a US resident and have a US physician
3. Ineligible for third party assistance
4. Completed applications reviewed on a case-by-case basis

Requirements: 1. Call and request enrollment forms
2. Physician must fill in section with a BLACK ball point pen
3. Enclose original prescription (s) which must NOT exceed a 90-day supply with a maximum of 3 refills
4. Physician and patient original signature required

Medications: Chibroxin
Cosopt
Lacrisert
Timoptic 0.25% & 0.50%
Trusopt 2%

Other Meds with Ophthalmic Use:
Cancidas, Indocin

Other: Blocadren, Clinoril, Cosmegen, Cozaar, Crixivane, Cuprimine, Demser, Diuril, Dolobid, Elspar, Emend, Fosamax, Hyzaar, Invanz, Mavacor, Maxalt, Maxalt MLT, Mephyton, Midamor, Moduretic, Mustargen, Noroxin, Pepcide, Primaxin, Prinivil, Prinizide, Propecia, Proscar, SIngulair, Stromectol, Syprine, Timolide, Vioxx, Zocor

Turnover: Three weeks

Duration: Three month supply

Refills: Patient calls 800-4-REFILL (473-3455) for refills
Reapply annually

Other:

1. Duplication of forms not accepted
2. Provider may make a request for an exception to the income guidelines with extenuating circumstances

KING PHARMACEUTICAL

Program Name: **KingKare Pharmaceuticals Patient Support Program**

Address: *Physician Requests Should Be Directed To:*
KingKare Patient Assistance Program
100 18th Street
Bristol, TN 37620

Phone: 877-546-5332 (M-F: 9-4 pm EST)

Fax: None, does not accept fax

Eligibility: 1. Deemed medically needy by the physician
2. No third party insurance
3. Based on monthly patient income adapted from federal poverty guidelines

Requirements: 1. Complete application form with original physician signature (not stamp)
2. Enclose original prescription with application
3. Complete a new application every 3 months

Medications: Viroptic 1% Ophthalmic Solution (7.5 ml bottle)

Other Meds: Altace capsules 1.25,2.5,5,10mg (bottle of 100)
Anusol-HC 2.5% Cream
Anusol-HC 25 mg Suppository
Corgard Tablets 20, 40, 80, 120, 160mg
Corzide Tablets 40/5, 80/5
Cytomel tablets tablets 5, 25, and 50mcg
Fluorinef tablets 0.1mg
Intal Nebulizer
Intal Inhaler
Kemadrin tablets 5 mg
Levoxyl tablets (25,50,75,88,100,112,125,137,150,175,200, and 300 mcg)
Lorabid capsules 200 and 400mg
Menest Tablets 0.3, 0.625, and 1.25mg
Menest Tablets 2.5mg
Ortho-prefest 1mg
Quibron capsules 150 mg
Quibron-T Accudose tablets 300 mg
Quibron-T/SR Accudose tablets 300 mg
Procanbid tablets 500 and 1000mg
Proctocort 1% cream
Proctocort 30 mg suppositories

Tapazole tablets 5 and 10mg
Thalitone tablets 15mg
Tilade Inhaler

Turnover: Allow 4-6 weeks for delivery

Duration: 3 months, complete application and attach prescription every 3 months

Contact: Bob White

**MYASTHENIA GRAVIS ASSOCIATION OF PENNSYLVANIA
(Patient assistance for ICN Pharmaceuticals)**

Program Name: **Myasthenia Gravis Assoc. of Western PA**

Address: *Physician Requests Should Be Directed To:*
Myasthenia Gravis Assoc. of Western PA
c/o Erin Thornbury
1323 Forbes Ave. Suite 201
Pittsburg, PA 15219

Phone: 800-783-7615 ext.25

Medication: Mestinon, Mestinon syrup, Mestinon timespan, Prostigmin

Eligibility: 1. Medicaid denial letter

Requirement: 1. Completion of form by physician
2. Enclose a prescription with specific instructions for use
3. After supply is sent (physician's office or pharmacy), a Receipt of Goods form must be completed and returned.

Supply: 90-day supply

Refill: Reapply annually

NORD—National Organization for Rare Disorders

Program Name: **Physician Services—BOTOX Assistance Program**

Address: *Physician Requests Should Be Directed To:*
Physician Services—BOTOX Assistance Program
PO Box 8923
New Fairfield, CT 06812-8923

Phone: 800-530-6680 (prescreening #/ reimbursement helpline)
800-999-NORD
203-744-0100 ext 224

Web: www.raredisease.org

Eligibility:

1. Deemed medically needy by physician
2. Ineligible for third party reimbursement or insurance denied
3. No child less than age 12 years

Requirements:

1. Completion of form by physician and patient
2. Patient form includes multiple questions aimed at determining monthly disposable income
3. Physician may not charge a fee for injection
4. Used for diagnosis: strabismus, blepharospasm, or hemi-facial spasm

Medication: BOTOX (Allergan)

Refill: Every year

Other:

1. Patient notifies program of their scheduled appointment 7-10 days in advance
2. Medication shipped to physician office in time for patient visit

Contact: Bunnie Navarette

NOVARTIS

Program Name: **Novartis Patient Assistance Program (PAP)**

Address: *Physician Requests Should BE Directed To:*
Novartis Patient Assistance Program
PO Box 8609
Somerville, NJ 08876

Phone: 800-277-2254

Eligibility:

1. Deemed “medically indigent” by their physician
2. Unable to provide for adequate healthcare coverage
3. Patients should not be reimbursed for medication under any third party health plan

Requirements:

1. Complete Novartis PAP application with original physician signature
2. Patient attaches copy of most recent federal tax return
3. Attach prescription for 3 month supply to equal stock bottle/ unit quantities

Medications: Famvir, Neoral, Sandimmune

Other Meds: Comtan, Desferal, Diovan, Diovan HCT, Exelon, Foradil*, Lamisil*, Lamprene, Lescol, Lotensin, Lotensin HCT, Lotrel, Miacalcin*, Migranal*, Parlodel, Sandostatin*, Sandostatin LAR Depot, Starlix, Tegretol, Tegretol XR, Trileptal, Trileptal Oral Suspension, Voltaren XR

Duration: 3 month supply (certain products provided in one month supply only*)

Turnover: 3 weeks

Refill: Complete a new form and new prescriptions every 3 months. Patient is eligible for up to one year (3 re-orders) with a cost-share fee to be paid by the patient.

NOVARTIS OPHTHALMICS (Includes CIBA VISION)

Program Name: **Novartis Ophthalmics Patient Support Program**

Address: *Physician Requests Should Be Directed To:*
Novartis Ophthalmics Patient Support Program
PO Box 52101
Phoenix, AZ 85072-9814

Phone: 877-855-5778
770-905-1611 (ophthalmic division phone)

Fax: 770-418-3466

Web: www.novartis.com

Eligibility: 1. Deemed “medically indigent” by physician
2. Ineligible for third-party reimbursement

Requirements: 1. Complete the Novartis Ophthalmics Information Form which includes: Date of Request; Physician name, address, and designation (MD, DO, OD); State License number or DEA number; Patient name; Specific Novartis Ophthalmic product requested (strength and size); Physician’s original signature (copy not accepted)
2. Enclose a completed prescription

Medications: AquaSite Lubricant Eye Drops (MD & SDU)
Eyescrub Pre-Moistened Pads
GenTeal Lubricant Eye Drops
HypoTears Lubricating Eye Drops
HypoTears PF Eye Drops
HypoTears PF/LF Ointment
Livostin Ophthalmic Suspension 0.05%
Ocupress
Rescula
Vasocon-A Ophthalmic Solution
Voltaren Ophthalmic Solution 0.01%

Duration: Six months

Turnover: Ten days

Refill: Reapply after six months

Contact: Company requested that no specific person be listed

NOVARTIS OPHTHALMICS, INC—Visudyne ONLY**

Program Name: **Visudyne Patient Assistance Program**

Address: Visudyne Patient Assistance Program
PO Box 4820
Gaithersburg, MD 20885-4280

Phone: 800-821-2450

Fax: 240-632-3815

Eligibility:

1. Patient must not have health insurance for physician services
2. Novartis Ophthalmic must receive proof of patient's household income to process application

Requirements:

1. Complete application form
2. Physician original signature
3. Include patient's most recent Federal Tax 1040 form
4. Physician must waive their laser fee as part of program

Duration:

1. One year
2. Visudyne will be sent to physician's office at 3 month intervals if the patient requires retreatment.

Turnover: 90 days

** This is a separate program. If you call the other Novartis Ophthalmic PAP program, they won't have any information on this Novartis Ophthalmic Visudyne Program.

ORTHO BIOTECH, Inc

Program Name: **PROCRITLINE**

Address: *Physician Requests Should Be Directed To:*
Ortho Biotech, Inc.
PROCRITline
1250 Bayhill Drive, Suite 300
San Bruno, CA 94066

Phone: 800-553-3851

Fax: 800-987-5572

Web: www.procritline.com

Eligibility:

1. Financially needy
2. Not on renal dialysis (see AMGEN program if on renal dialysis)
3. Recent Hemoglobin/Hematocrit (demonstrate anemia)
4. Company provides insurance verification

Requirements:

1. Obtain enrollment form and doctor complete information and sign
2. Patient signature required
3. Patient must provide proof of income
4. Fax form back to PROCRITline

Medication: Procrit (Epoetin)

Other: Leustatin, Doxil

Dispensed: Medication sent directly to physician office or patient can receive a pharmacy card that they bring to their pharmacist

Duration: 1 application is good for 6 months

Refill: Company will contact doctor's office for refill information
After six months, the company will contact the patient to renew
Proof of income required annually

Limit: Indefinite

ORTHO-McNEIL PHARMACEUTICALS

Program Name: **Ortho-McNeil Pharmaceutical Patient Assistance Program**

Address: *Physician Requests Should Be Directed To:*
Ortho-McNeil
Patient Assistance Program
1250 Bayhill Drive Suite 300
San Bruno, CA 94066

Phone: 800-577-3788

Fax: 509-691-4858

Web: www.orthomcneil.com

Eligibility:

1. Based directly on financial criteria
2. Ineligible for third party reimbursement
3. Eligible for one year

Requirements:

1. Completion of information form, can download form
2. Original prescriptions
3. Proof of patient income
4. Original patient and physician signatures

Medications: Discontinued all ophthalmic medications

Turnover: UPS shipped—5-7 business days to physician office

Refill: Quantity limited to 3 month supply

Other: Bicitra, Dermatop, Ditropan, Ditropan XL, Elmiron, Floxin, Grifulvin
Haldol, Levaquin, Monistat, Mycelex Troche, Neutra-Phos
Neutra-Phos K, Pancrease, Parafon, Polycitra, Polycitra K
Regranex, Renova, Retina-A, Spectazole, Terazol, Testoderm
Tolectin, Topomax, Ultracet, Ultram, Urispas, Vasacor

PFIZER—DIFLUCAN AND ZITHROMAX PROGRAMS

Program Name: **Pfizer Diflucan and Zithromax Patient Assistance Program**

Address: Pfizer Diflucan and Zithromax Patient Assistance Program
PO Box 230518
Centreville, VA 20120-9979

Phone: 800-869-9979 (8:30-5:30 M-F)

Fax: None

Eligibility:

1. Resident of the United States
2. Ineligible for third party reimbursement
3. Single patient must have household income of less than \$25,000 and patients with dependents must have income less than \$40,000
4. Pfizer will not reimburse pharmacies
5. Zithromax program is for patients taking 1200mg for the prevention of MAC
6. Ineligible for State AIDS program

Requirement: 1. Physician and patient complete application

Supply: Three month supply

Turnover: Four weeks for refills

PFIZER INC. (Living Share Card Program)

Program: **Pfizer for Living Share Card**

Address: Pfizer for Living Share Card
PO Box 347
Hanover, MD 21076

Phone: 800-717-6005 (24 hour call center)

Eligibility: 1. Be enrolled in Medicare
2. Have no prescription drug coverage and not be eligible for Medicaid or any publicly funded drug benefit plan AND who have a single family household income less than \$18,000 or family income less than or equal to \$24,000

Requirements: 1. Call phone number above to begin process
2. Complete application form with original signatures
3. Take Share card to pharmacy, pay \$15, receive 30-day supply

Ophthalmic: Terramycin Ophthalmic Ointment
Vibramycin (Doxycycline)

Other Meds with Ophthalmic implication:

Diabinese, Glucotrol, Glucotrol XL, Diflucan, Viracept, Zithromax

Other: Accupril, Accuretic, Antivert, Aricept, Atarax, Cardura, Celebrex, Celontin, Covera, Cytotec, Detrol, Detrol LA, Dilantin, Estrocept Fe and 21, Feldene, Femhrt, Geocillin, Geodon, Lipitor, Loestrin, Lopid, Minipress, Minizide, Nardil, Navane, Neurontin, Nitrostat, Norvasc, Procardia, Procardia XL, Renese, Rescriptor, Sinequan, TAO, Tikosyn, Viagra, Vistaril, Zarontin Zolofit, Zyrtec, Zyrtec-D 12 Hour

Duration: 30-day supply

PFIZER

Program Name: **Pfizer Connection To Care Program**

Address: *Physician Requests Should Be Directed To:*
Pfizer Connection to Care Program
PO Box 66585
St. Louis, MO 63166-6585

Phone: 800-707-8990

Eligibility: 1. Less than \$16,000 for individual; less than \$25,000 for family
2. Ineligible for third party reimbursement
3. Must not be eligible for Medicare or Medicaid

Requirements: 1. Patients must submit tax return and supporting financial documents annually
2. Completed application with physician DEA# or state licence #
3. Original signed prescription from their physician

Medications: Ocuhist
Visine Original
Visine AC
Visine LR

Medications with Ophthalmic Use:
Diabinese
Glucotrol and Glucotrol XL
Vibramycin

Other Meds: Any medication manufactured by Pfizer except: Birth control pills and narcotics
Accupril, Accuretic, Antivert, Cardura, Dilantin, Feldene, Lipitor, Minipress, Minizide, Navane, Neurontin, Procardia, Procardia XL, Relpax, Sinequan, Viagra, Vistaril, Zarontin, Zolofte, Zyrtec

Supply: 90-day supply

Turnover: 3-4 weeks after letter received

Refill: Every three months (repeat prescription)

Other: May photocopy application but original physician signature required

PHARMACIA COMPANY

Program Name: **Pharmacia Patient Assistance Program**

Address: *Physician Requests Should Be Directed To:*
Pharmacia Corporation Patient Assistance Program
PO Box 52059
Phoenix, AZ 85072

Phone: 800-242-7014

Eligibility: 1. Deemed medically needy
2. No third party prescription coverage
3. Short-term program

Requirements: 1. Patient or physician can enroll patient over the phone
2. Application sent to office for physician/patient completion
3. Card issued to pick up 1st bottle of Xalatan at local pharmacy.
4. If patient qualifies for program, a card is issued to the patient to receive Xalatan at any pharmacy
5. Patient pays \$5 copay for each bottle

Medications: Xalatan

Other Medications with Ophthalmic Use:
Mycobutin

Other Meds: Activella, Arthrotec, Axert, Bextra, Celebrex, Cleocin Vaginal, Covera-
HS, Cytotec, Detrol, Detrol LA, Dostinex, Estrin, Estrin, Estrin, Estrin, Estrin, Estrin,
Halotestin, Mirapex, Pletal, Vagifem, Zyvox

Duration: Six Months

Refill: 1. Short-term program primarily
2. Can re-enroll for a second six-month term but patient must pay half the prescription cost and \$5 copay

ROCHE LABS

Program Name: **Roche Medical Needs Program**

Address: *Physician Requests Should Be Directed To:*
Medical Needs Department
Roche Laboratories Inc.
340 Kingsland Street
Nutley, NJ 07110-1199

Phone: 800-285-4484 General Information (8:30-5:00 EST)
800-282-7780 Cytovene medical info line
800-282-7780 Hivid, Invirase, Fortovase info line
800-526-6367 Emergency line
800-772-5790 Transplant reimbursement hotline
800-443-6676 Oncology line

Eligibility: 1. Immunosuppressed patient with CMV retinitis (must be able to document HIV viral load, CD4 count)
2. Ineligible for third party outpatient prescription drug coverage
3. Financially indigent
4. Outpatient (not hospitalized)

Requirements: 1. Roche analyzes each patient's financial situation case by case
2. Encourage phone enrollment (by physician office only)
3. Requests a completed application
4. Requires original physician signature on application and physician *DEA#*
5. Three month supply sent directly to physician's office
6. Proof of patient's income and a copy of the patient's tax return or W2 form must be attached

Medications: Cytovene tablets, Cytovene IV

Other Medications with Ophthalmic Use:
Fortovase, Fuzeon, Hivid, Invirase,

Other Meds: Accutane, Anaprox, Bumex, Cardene, Cellcept, Demadex,
Klonopin, Naprosyn, Rocaltrol, Rocephin, Roferon-A,
Soriatane, Ticlid, Valium, Vesanoide, Xeloda

Turnover: 3-5 working days after application complete

Refill: Re-enroll yearly

ROCHE LABS

Program Name: **Roche Medical Needs Program**

Address: *Physician Requests Should Be Directed To:*
Medical Needs Department
Roche Laboratories Inc.
340 Kingsland Street
Nutley, NJ 07110-1199

Phone: 877-757-6243

Eligibility: 1. Ineligible for third party outpatient prescription drug coverage
2. Financially indigent

Requirements: 1. Roche analyzes each patient's financial situation case by case
2. Encourage phone enrollment (by physician office only)
3. Requests a completed application
4. Requires original physician signature on application and physician
DEA# and patient signature

Other Meds: Accutane, Anaprox, Bumex, Cardene, Cellcept, Demadex,
Klonopin, Naprosyn, Rocaltrol, Rocephin, Roferon-A,
Soriatane, Ticlid, Valium, Vesanoid, Xeloda

Turnover: 3-5 working days after application complete

Refill: Re-enroll yearly

RX HOPE.

Program Name: **RxHope**

Address: *Physician Requests Should Be Directed To:*
RxHope
254 Mountain Avenue
Building B Suite 200
Hackettstown, NJ 07840

Phone: 908-850-8004

Fax: 908-850-8269

Web: www.rxhope.com

Eligibility: 1. Physician with DEA# must register on site
2. Can apply for over 1000 medications on web

Requirements: 1. Complete online application which is encrypted and secured

Medications: Extensive list—cumulative list of all pharmaceutical companies with patient assistance programs

SANTEN INC.

Program Name: **Santen Patient Assistance Program**

Address: *Physician Requests Should Be Directed To:*
Santen Patient Assistance Program
PO Box 29094
Phoenix, AZ 85038-8712

Phone: 866-815-6874 (toll free)

Email: info@santeninc.com
www.santeninc.com

Eligibility:

1. Deemed medically and financially needy by a physician
2. Ineligible for third party assistance
3. Completed application reviewed on a case-by-case basis
4. US citizen

Requirements:

1. Obtain enrollment form and complete all parts
2. Physician and patient signatures required
3. Can't copy application, carbon inside

Medications: Betimol 0.25% (2 bottles, 15 ml)
Betimol 0.5% (2 bottles, 15 ml)

Turnover: Ten days

Duration: Six month supply.

Refill: Reapply after six months. May participate as long as the patient meets eligibility criteria.

WYETH

Program Name: **Wyeth Pharmaceutical Assistance Foundation**

Address: *Physician Requests Should Be Directed To:*
Wyeth Pharmaceutical Assistance Foundation
PO Box 13806
Philadelphia, PA 19101-9649

Phone: 800-568-9938

Fax: Not Accepted

Eligibility:

1. Deemed medically and financially needy
2. Ineligible for third party reimbursement
3. Annual income less than or equal to program guidelines

Requirements:

1. Complete Wyeth application form with original signature of patient and physician
2. Physician referral program only
3. Prescriptions are not needed
4. Complete Wyeth Prescription Assistance Authorization Form (HIPAA attachment)

Medications: Phospholine Iodide 6.25mg/5ml

Other Meds: All manufactured products except over-the-counter, controlled substances, injectables, and oral contraceptives
Cordarone, Declomycin, Effexor, Effexor XR , Inderal, Inderide, Lodine, Lodine XL, Minocin, Oruvail, Phenergan, Premarin, Premphase, Prempro, Protonix, Trecator-SC

Turnover: 4-6 weeks

Supply: Three-month supply sent directly to physician office

Refill: New application every 3 months

Contact: John E. James
Manager of Professional Services

Other:

1. Can duplicate enrollment forms but requires original signature of patient and physician
2. No direct calls from patients