

**PREZISTA™ (darunavir) 300 mg tablets
 PATIENT ASSISTANCE PROGRAM
 ELIGIBILITY APPLICATION FORM
 Telephone 866-836-0114**

Online SUBMISSION and Copies of this form are
 Available at www.TibotecTherapeuticsLine.com
 Mail or fax this completed form to:
 TibotecTherapeuticsLine, P.O. Box 1016, San Bruno, CA 94066

Fax 1-866-836-0567

| | | | |
|---|--|------------------------------|-----------------------|
| Patient Information (Please Print Clearly) | | | |
| New Application Yes ___ No ___ | | Renewal Yes ___ No ___ | |
| Name of Patient _____ | | M ___ F ___ | |
| Name of Guardian (if appropriate) _____ | | | |
| Patient's Address _____ | | City _____ | State _____ Zip _____ |
| Phone Number – Home _____ | | Phone Number – Work _____ | |
| Date of Birth _____ | | Social Security Number _____ | |

| | | | |
|--|--|-------------|-----------|
| Provider Information (Please Print Clearly) | | | |
| Name of Physician _____ | | | |
| Practice or Facility Name _____ | | | |
| Address _____ | | | |
| Line 1 _____ | | | |
| Line 2 _____ | | | |
| City _____ | | State _____ | Zip _____ |
| Office Phone Number _____ | | | |
| Office Fax Number _____ | | | |
| Office Contact Name _____ | | | |
| Office Contact Telephone _____ | | | |

Does this patient have insurance coverage for PREZISTA™ (darunavir) 300 mg tablets? ___ Yes ___ No
 Has patient applied to public programs such as ADAP or other drug assistance program? ___ Yes ___ No
 If Yes, date applied _____
 If yes, to which programs? _____

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| Prescription Information | | |
| Name of Drug PREZISTA™ (darunavir) 300 mg tablets | | |
| Dose _____ | Sig _____ | Quantity _____ |
| “Is the patient currently taking PREZISTA™ (darunavir) 300 mg tablets?” ___ Yes ___ No | | |
| Expected Duration of Therapy (months) _____ | | |
| Physician Signature _____ | | |
| Physician State License Number _____ | | |

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|--|----------|
| Financial Qualification for Program | |
| I have _____ estimated net assets. | |
| Gross Annual Household Income and Source of Income | |
| Salary/Wages/Unemployment | \$ _____ |
| Pension/Social Security | \$ _____ |
| SSI | \$ _____ |
| SSDI | \$ _____ |
| Other | \$ _____ |
| | \$ _____ |
| | \$ _____ |
| Total | \$ _____ |
| I have \$0 income. _____ (check if applicable) | |
| Number of household members dependent on income stated above (include applicant) _____ | |

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| Direct Shipment Instructions |
| Please provide special shipping instructions for product shipped directly to physician office or hospital facility (i.e. office hours available for delivery) |
| _____ |
| _____ |

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|---|------------|
| Proof of Income Documentation | |
| Attached is a copy of my most recent federal tax return. (X) | |
| I do not file federal taxes. (X) | |
| Applicant Declaration. “I promise that the information on this form is correct and complete. If needed, Tibotec Therapeutics and its Patient Assistance Program (the “Program”) may request and obtain information about my, or my family’s income to enroll me in the Program. I understand that the Program administrators reserve the right any time and without notice to modify the application form; modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time.” | |
| Please indicate your agreement with these terms by signing below. | |
| | Date _____ |
| Patient Signature or Authorized Representative _____ | |
| If Representative, please explain relationship _____ | |

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|---|------------|
| Physician Declaration | |
| To the best of my knowledge, this patient does not have prescription drug coverage (including Medicaid, county funded assistance, or other public programs) for PREZISTA™ (darunavir) 300 mg tablets. The PREZISTA™ (darunavir) 300 mg tablets. Patient Assistance Program requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient’s health insurer. No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product or administration of product provided under the program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient’s prescription. | |
| Physician Signature _____ | Date _____ |

**Authorization to Share Health Information for Reimbursement
or Patient Assistance Programs**

Provider Instructions: Patients must complete this form before they can participate in the Program.

I, _____, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for PREZISTA™ (darunavir) 300 mg tablets to Lash Group. Lash Group runs the Reimbursement and Patient Assistance Programs (the "Programs") for Tibotec Therapeutics, a Division of Ortho Biotech Products, L.P.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

Lash Group and Tibotec Therapeutics will use and give out this information to see if I qualify for the Programs and to run the Programs. People who work for and with Lash Group and Tibotec Therapeutics may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Programs. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Tibotec Therapeutics, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Tibotec Therapeutics.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Programs.

Patient Sign Here: _____ Date: _____

Patient Name: _____

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: _____

By: _____
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:

A copy of this form must be provided to the patient.