



P.O. Box 66547
St. Louis, MO 63166-6547

Dear Patient or Health Care Provider:

Thank you for your interest in the Purdue Patient Assistance Program. To be eligible for the Purdue Patient Assistance Program, patients must be a **U.S. resident**, meet income requirements, and must not have prescription drug coverage from an insurance provider including Medicare, Medicaid or any other federal or state program. There is also a **\$25.00 co-pay per prescription payable only by money order or certified bank check (cashier's check) to Purdue PAP (Please do not send cash or personal checks)**. To avoid delay, please use the enclosed application. Please complete the following steps to apply for the Purdue Patient Assistance Program.

1. Complete all patient and physician sections of the attached application; both patient and physician must sign application (signatures must be original).
2. Please include an original prescription written by a MD or DO. (For OxyContin prescriptions, only FDA approved dosing of OxyContin® every 12 hours will be allowed. Doses cannot exceed 360 pills per prescription/per month.)
3. Please include a \$25.00 money order or certified bank check (cashier's check) for each prescription payable to Purdue PAP (Example: If a patient receives 3 different prescriptions, a \$75.00 money order should be enclosed.)
4. Attach a copy of the patient's most recent year federal tax return or financial documentation (examples include: IRS Form 1040, 1040EZ, 1040X, 4506T, 8453, 8879, 1099, 1099R, 1099RR, and Social Security or Disability statement).
5. Attach a copy of the patient's driver's license or state ID.
6. Attach a copy of the patient's social security card, green card, or visa.
7. Mail the application, original prescription, \$25.00 money order or certified bank check (cashier's check) for each prescription, copy of driver's license or state ID, copy of social security card, green card or visa, and financial documentation to:

PURDUE PATIENT ASSISTANCE PROGRAM

PO BOX 66547

ST. LOUIS, MO 63166-6547

We will review and process the patient's eligibility once we receive the completed application, original prescription, \$25.00 co-pay for each prescription, copy of driver's license or state ID, copy of social security card, green card, or visa, and financial documentation. You will receive written notification concerning the patient's eligibility in up to 10 business days.

If you have any questions, please call a Purdue Patient Assistance Program representative at 1-800-599-6070, Monday through Friday, 7:30 am to 5:00 pm CST.

Sincerely,

Purdue Patient Assistance Program



Patient Assistance Program

Mail the application, financial documentation, \$25.00 co-pay per prescription, copy of driver's license or state ID, copy of social security card, green card or visa, and prescription to:
 Purdue Patient Assistance Program
 P.O. Box 66547
 St. Louis, MO 63166-6547

IMPORTANT - PLEASE COMPLETE THIS APPLICATION AND FOLLOW THE INSTRUCTIONS BELOW:

1. Enclose a valid prescription (not to exceed 30 days).
2. Include a money order or certified bank check (cashier's check) for \$25.00 for each prescription payable to Purdue PAP (Please do not send cash or personal checks.)
3. Attach copy of driver's license or state ID.
4. Attach copy of social security card, green card, or visa.
5. Attach Proof of Income (Examples include IRS Form 1040, 1040EZ, 1040X, 8453, 8879, 4506T, 1099, 1099R, 1099RR, social security or disability statement, etc.)

Section 1 - Physician Information

Physician Name	DEA	Phone: ()	
Address:	City:	State:	Zip:
Physician Signature (original signature):		Date:	

Physician/Prescriber Attestation: My signature certifies that (1) this patient has demonstrated medical and financial need for assistance and has consented to share; upon request, his or her health and financial information with Purdue Patient Assistance Program and its contractors to confirm eligibility and to administer participation in the program, and (2) this information is accurate and complete to the best of my knowledge.

Section 2 - Patient Information

Patient Name:		SS#:	
Street Address (No P.O. Box):		Date of Birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
City	State	Zip	Phone ()
Number of Household members (including self)? (circle one) 1 2 3 4 5 6 7 other	U.S. Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you a Veteran of the US Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you Disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>

Allergies: Yes No If Yes, please list:

Financial Information Note: You must attach copy of your most recent U.S. Income Tax Return, i.e., IRS Form 1040, 1040A, 1040EZ, 1040NR

List All Sources, Gross Monthly Amounts

Salary/Wages \$ _____	Social Security \$ _____	Alimony/Child Support \$ _____
Disability \$ _____	Pension/Retirement \$ _____	Unemployment/Workers Comp \$ _____

Total Gross Household Monthly Income: \$ _____

Total Patient Assets: \$ _____ (This includes savings/checking, IRA, annuities, stocks/bonds/CDs)

Insurance Information	Check one	Insurance Information	Check one
Private Drug Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part D	<input type="checkbox"/> Yes <input type="checkbox"/> No

I attest that the information provided in this application is complete and accurate. I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, mental, alcohol or drug abuse history, treatment or benefits payable, to any other party necessary for the purpose of validating and determining benefits payable, case management, reporting requirements or administration of the patient assistance program. I understand that the Purdue IPAP reserves the right to refuse to enroll me or disenroll me from the patient assistance program based on any unintended use, abuse or illegal distribution of any products in this program.

I authorize the Supplier of the Patient Assistance Program ("Program") to disclose to Purdue, all personal information relating to my medical condition, treatment and insurance coverage needed to administer my participation in the Program. I understand that if I refuse to sign this authorization, I will not be able to participate in the Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment or affect my insurance enrollment or eligibility for insurance benefits. I understand that I may cancel this authorization at any time by mailing a letter to the Program. Canceling this authorization will prohibit disclosure of my personal information after the date the cancellation letter is received and processed but will not affect disclosure made before that time. I understand that once my personal information is disclosed to Purdue, federal privacy laws may no longer protect the information from further disclosure. This authorization or a copy shall be valid for up to 12 months from the date of signature. I attest that I do not have the ability to pay for my medication and I am not and will not receive my Purdue medication through Medicare, Medicaid, VA, military, state or local plans or any private insurance

Patient's Signature (original signature):	Date:
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