Medunik USA

Patient Assistance Program

Phone 866-610-7787 | Fax 844-375-3010

STEP 1 - PATIENT INFORMATION - TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

Last Name	First Name		Middle initial
Address			APT #
City	State	ZIP	Email address
Gender ☐ Female ☐ Male	Date of Birth (mm/dd/yyyy)	Are you a U.S. Resident? ☐ Yes ☐ No	
Gross Annual Household Income	Number of Persons in Household	Social Security #	

— Proof of Income Documentation is required for this program. Please select the documents you intend to submit. —

Federal Tax Return ☐	Social Security Income ☐	Bank Statements/ Paycheck Stubs (minimum of 3) ☐	Other:

STEP 2 - PATIENT INSURANCE INFORMATION - TO BE COMPLETED BY PATIENT OR PATIENT CAREGIVER

What type of insurance coverage do you have?

NO Insurance Coverage ☐		**Other:**	
Medicare Part A/B Medicare Part D ☐	**Medicare Advantage** ☐	**Medicaid** ☐	**Employer** ☐

— For each insurance policy you have, please attach a copy of both sides of your insurance card and fill in the following —

Primary Insurance Name	**Secondary Insurance Name**
Phone Number	Phone Number
Policy ID	Policy ID
RxGRP	RxGRP
PCN	PCN
RxBIN	RxBIN

I hereby authorize any hospital, physician or any other healthcare provider to disclose to Medunik USA and its agents all medical records and information, financial as well as other identifying information, for the purpose of my participation in the Medunik USA Patient Assistance Program. I understand that any information that reveals my identity will not be used for any purpose other than that described above. I attest that I have insufficient financial resources to pay for the prescribed therapy. By my signature, I authorize the release of the information about me and my medical condition to the Medunik USA Patient Assistance Program and/or their agents. I further authorize Medunik USA to release the medical and insurance information contained on this form, as well as, medical history information submitted by my provider's office to ProCare Pharmacy Care or affiliated Specialty Pharmacies for the purpose of having this patient's insurance reviewed for eligibility status. I further authorize ProCare Pharmacy Care, my authorized agent, to contact my insurance provider to receive coverage updates or decisions. This information may be used for processing pharmacy billing or claims through my insurer or for qualification of benefits through Medunik USA or other purposes as I direct.

Patient Signature: _____ **Date:** _____

STEP 3 - PROVIDER INFORMATION - TO BE COMPLETED BY HEALTHCARE PROFESSIONAL OR OFFICE

DEA Number	NPI Number	Expiration Date	
State License Number		Expiration Date	
Physician First Name	Physician Last Name	Prof Designation:	
Address	State	ZIP	
Office Contact	Phone Ext.	Fax	

STEP 4 - PRESCRIPTION INFORMATION - ATTACH A WRITTEN PRESCRIPTION ALONG WITH THIS FORM

I verify that the information provided is complete and accurate to the best of my knowledge. Medunik USA through it's Medunik USA Reimbursement and Patient Assistance Program reserves the rights to request additional information if needed and to change or discontinue this program at any time without notice. By signing this form, I certify that I am prescribing the aforementioned medication for my patient participating in the Medunik USA Reimbursement and Patient Assistance Program. I understand that the medication prescribed above shall be sent directly to my written address, and I certify that the medication requested shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party insurance provider.

Healthcare Provider Signature: _____ **Date:** _____

Patient Assistance Program

PLEASE DO NOT FAX THIS PAGE BACK

PROGRAM QUALIFICATIONS

- **Patient's annual household income must be at or below 250% of the current Federal Poverty Level.**
- **Patient does not have prescription coverage through any Private Insurance, State or Federal Program.**
- **Patient must be a US resident**

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS FOR SIKLOS®

- **Application must be completed, signed and dated by both the Healthcare Professional and Patient.**
- **Patient must submit Proof of Income:**
  Federal Income Tax (form 1040 or 1040EZ) with appropriate schedules (C and/or F) or Federal Income Tax Form 1099 or Yearly benefits statement (SSA, 1099, etc) or Past three bank statements showing automatic deposit for the current calendar year or Past three current pay stubs
- **Fax completed application to 844-375-3010**
- **The requested medication will ship to the Health Care Provider's office.**
- **Every six months, the Health Care Provider and the Patient must sign and submit a new application.**

LEGAL DISCLAIMER

The Program is not intended to supplement or supplant third-party prescription drug coverage by public or private payers. While Medunik USA will make every effort to grant aid when needed, the Program is limited by available resources and may be discontinued or changed at any time. Prior to application to Medunik USA, the medical provider should determine that the patient is an outpatient, ineligible for third-party outpatient prescription drug coverage under private insurance, government funded programs (Medicaid, Medicare, VA), or private/community sources, and unable to afford the cost of therapy on their own. Medunik USA products are offered to patients through licensed practitioners with valid DEA and state license numbers. The Program is for individual patients who fall within the Patient Assistance Program pre-established criteria. It is not intended for clinics, hospitals and/or other institutions. This application must be completed to enter new patients into the Program. The medical provider's signature is required on all applications. Once the application is received and it is determined the patient qualifies for the Program, delivery may take up to one week.

SIK-2018-0028-02 Sept 2018