



**Patient Assistance & Support**  
 6900 College Boulevard Suite 1000  
 Overland Park, Kansas 66211  
 Phone: 1-888-CARES-55  
 Fax: 1-877-9-CARES-9

Thank you for your interest in the Shire Cares Patient Assistance & Support Program. If you are having trouble affording your Shire medicines, this program is designed for you.

The type of assistance available varies based on the product that has been prescribed for you, your household income, and your insurance status. To receive prescription drug assistance from Shire Cares, you and your doctor must complete and submit this application form in its entirety. We have included a checklist at the bottom of this page to guide you through completing and submitting your application.

If you have any questions, please call the program at 1-888-CARES-55 (1-888-227-3755). We are available to answer your calls Monday through Friday, from 8 AM to 8 PM Eastern Time.

Please note: Submission of a complete application form does not guarantee enrollment in Shire Cares. Each application will be considered on a case by case basis. For your convenience, the general income guidelines for free product assistance are included below.

Number of People in Your Household	Maximum Total Yearly Income
1 person	\$32,670
2 people	\$44,130
3 people	\$55,590
4 people	\$67,050
5 people	\$78,510

**APPLICATION CHECKLIST:** Use this to help make sure you complete and submit your application properly

**DOCTOR**

- Complete all fields in Section 1
- Fill out prescription information in Section 2
- Indicate medication shipping preference in Section 2
- Sign and date the application form ( no stamps; only original signatures accepted)

**PATIENT**

- Fill out your personal information in Section 3
- Fill out your financial information in Section 4
- Attach proof(s) of income for your household
- If you have health insurance: fill out your insurance information in Section 5 and attach a copy of your insurance card
- Sign and date the application form

**When you and your doctor have completed both checklists above,** send your form to us by fax or mail. Incomplete or incorrect information may delay the processing of your application, so please ensure that all information is provided correctly and that all signatures are obtained.

Fax: 1-877-9-CARES-9 (1-877-922-7379)  
 Mail: Shire Cares Patient Assistance & Support Program  
 6900 College Boulevard, Suite 1000  
 Overland Park, Kansas 66211

The documents accompanying this fax transmission may contain confidential information. This information is intended only for the use of the individual or entity named above. If you have received this fax in error, please notify the sender at 1-877-9-CARES-9.



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**PHYSICIAN COMPLETES THIS PAGE**

**SECTION 1: TREATING & REFERRING (if applicable) PROVIDER INFORMATION**

**Treating Physician Name** \_\_\_\_\_ DEA # **\*** \_\_\_\_\_  
 National Provider ID \_\_\_\_\_ Medical License # \_\_\_\_\_  
 Facility Name \_\_\_\_\_ Tax ID \_\_\_\_\_  
 Address (No PO Box) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Ext \_\_\_\_\_ Secure Fax \_\_\_\_\_  
 Clinic Contact \_\_\_\_\_ Contact Title \_\_\_\_\_

**Referring Physician Name** \_\_\_\_\_ DEA # \_\_\_\_\_  
 National Provider ID \_\_\_\_\_ Medical License # \_\_\_\_\_  
 Facility Name \_\_\_\_\_ Tax ID \_\_\_\_\_  
 Address (No PO Box) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Ext \_\_\_\_\_ Secure Fax \_\_\_\_\_  
 Clinic Contact \_\_\_\_\_ Contact Title \_\_\_\_\_

**\*DEA Identification number required only if prescribing a controlled substance**

**SECTION 2: THIS IS THE PRESCRIPTION; NO ADDITIONAL PRESCRIPTION IS NEEDED**

**Patient Name** \_\_\_\_\_ **Patient Date of Birth** \_\_\_\_\_  
**Diagnosis**  Epilepsy  Trigeminal Neuralgia  Ulcerative Colitis  
 Attention-Deficit/Hyperactivity Disorder (ADHD)  Hyperphosphatemia with End Stage Renal Disease (ESRD)  
*Please Note: Coverage can only be provided for diagnoses indicated above.*

Product (please select)	Dosage	Administration	Distribution	Refills (please select)
<input type="checkbox"/> Vyvanse® (lisdexamfetamine dimesylate) Capsules CII		Prescription given to patient for use at pharmacy	<input checked="" type="checkbox"/> Pharmacy Card	
<input type="checkbox"/> Carbatrol® (carbamazepine) Extended-Release Capsules			<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 01 <input type="radio"/> 02 <input type="radio"/> 03
<input type="checkbox"/> FOSRENOL® (lanthanum carbonate) Chewable Tablets			<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 01 <input type="radio"/> 02 <input type="radio"/> 03
Total Daily Dose:				
<input type="checkbox"/> Lialda® (mesalamine) Delayed Release Tablets			<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 01 <input type="radio"/> 02 <input type="radio"/> 03
<input type="checkbox"/> PENTASA®(mesalamine) Controlled Release Capsules			<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 01 <input type="radio"/> 02 <input type="radio"/> 03
<input type="checkbox"/> INTUNIV®(guanfacine) Extended Release Tablets				
Is patient new to treatment?				
<input type="checkbox"/> No → Complete prescription here			<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 01 <input type="radio"/> 02 <input type="radio"/> 03
<input type="checkbox"/> Yes → A total of up to 90 tablets may be prescribed for your patient's initial titration shipment.				
Dosage & Quantity 1 mg _____ (qty) 2 mg _____ (qty) 3 mg _____ (qty) 4 mg _____ (qty)				
Administration _____				

*Please Note: Coverage will not exceed the maximum daily dosage as indicated within each product's prescribing information.*

**Ship Product to:**  Physician's Office  Patient's Address *(If no selection is made, product will be shipped to Patient's Address)*

**Physician / Prescriber Attestation**

I represent that the information contained in this application is complete and accurate. I certify that this prescription is medically indicated for this patient and that I will be supervising this patient's treatments. I verify that to the best of my knowledge, this patient has no prescription insurance coverage for the product prescribed, including all public programs, and the patient has insufficient financial resources to pay for the prescribed medication. I understand that Shire reserves the right to modify or terminate this program at any time. Furthermore, my signature certifies that these goods will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I understand that Shire reserves the right to recall the product, if necessary.

Original Signature of Licensed Practitioner (no stamps accepted) \_\_\_\_\_ Date \_\_\_\_\_



**SECTION 3: PATIENT PERSONAL INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Phone \_\_\_\_\_ Gender  Male  Female  
 Social Security Number \_\_\_\_\_ US Citizen / Legal Resident?  Yes  No  
 Address (No PO Box) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Contact Name (if other than patient) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**SECTION 4: PATIENT FINANCIAL INFORMATION**

Number of people in your household Adults = \_\_\_\_\_ Children = \_\_\_\_\_  
 Total combined income for you, your spouse, and your dependents \$ \_\_\_\_\_ Annually  
 You must provide proof of income to apply for this program. Please provide a copy of your most recent:  
 Federal Tax Return **or**  Pay Stubs (full month's worth of recent pay stubs) **or**  
 Social Security Income Yearly Benefits Statement  
 Have you lost your job in the past three (3) months?  Yes  No → If Yes, please attach proof of job termination or unemployment.

**SECTION 5: PATIENT INSURANCE INFORMATION**

Do you have any insurance coverage for prescription drugs?  Yes  No → If No, leave this section blank and skip to Section 6.  
 What type of insurance coverage do you have? (Check all that apply)  
 Medicare Part A  Medicare Part B  Medicare Part D  Medicare Advantage  Medicaid  
 State Pharmacy  Employer  Other \_\_\_\_\_ (Please fill in Name of Insurer)  
 For each policy you have, please attach a copy of both sides of your insurance card and fill in the following:  

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Name _____	Insurance Name _____
Phone Number _____	Phone Number _____
Policy ID _____	Policy ID _____
Group Number _____	Group Number _____

 Have you recently received a Denied Prior Authorization Letter for this product?  Yes  No → If Yes, please attach the denial letter.  
**\*\*If the product is not covered by your plan please provide a patient specific letter from the insurance company stating no coverage.**  
 Are you a Veteran?  Yes  No → If Yes, have you applied for VA?  Yes  No

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other health care provider to disclose to Shire US Inc. and its agents all medical records and information, financial and insurance records and information as well as other identifying information, for the purpose of my participation in the Shire Cares Patient Assistance Program. I also authorize Shire US Inc. and its agents to disclose all such records and information to any persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate and I have no prescription coverage for the prescribed treatment, including all public programs, and have insufficient financial resources to pay for the prescribed treatment. I understand that Shire US Inc. reserves the right at any time and without notice to modify the application or modify or discontinue this program and related eligibility criteria. I authorize Shire US Inc. to use my Social Security Number for identification purposes and record keeping only.

Patient Name (Print) \_\_\_\_\_  
 Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 → If patient cannot sign or is <18 years of age, patient's representative must sign below  
 Patient Representative Name & Relationship to Patient (including description of authority to make medical decisions for patient)  
 \_\_\_\_\_  
 Patient Representative Signature \_\_\_\_\_ Date \_\_\_\_\_