



P.O. Box 5666
 Louisville, Kentucky 40255-0666
 Phone: 1-888-CARES-55 (1-888-227-3755)
 Fax: 1-877-9-CARES-9 (1-877-922-7379)

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

The type of assistance available varies based on the medicine that has been prescribed for you, your household income, and your insurance status. To receive prescription medicine assistance from Shire Cares, you and your doctor must complete and submit this application form in its entirety, and meet program eligibility requirements. 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, except for Holidays.

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 assistance with your Shire medicines are included below.

Number of People in Your Household	Total Yearly Income
1 person	\$36,180
2 people	\$48,720
3 people	\$61,260
4 people	\$73,800
5 people	\$86,340

Please check one:

- New Application
 Renewal Application

APPLICATION CHECKLIST: Please ensure all items on the list are completed and attached, or the application may be delayed

- | | |
|--|--|
| <input type="checkbox"/> Complete all fields in Section 1 | <input type="checkbox"/> Fill out your personal information in Section 3 |
| <input type="checkbox"/> Fill out prescription information in Section 2 | <input type="checkbox"/> Fill out your financial information in Section 4 |
| <input type="checkbox"/> Indicate medicine shipping preference in Section 2 | <input type="checkbox"/> Attach proof(s) of income for your household |
| <input type="checkbox"/> Sign and date the application form (no stamps; only original signatures accepted) | <input type="checkbox"/> If you have health insurance: fill out your insurance information in Section 5 and attach a copy of your insurance card |
| | <input type="checkbox"/> Complete Section 6 |

Please keep a copy of the application for your records

When you and your doctor have both completed the checklist above, send your form and attachments 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
 P.O. Box 5666
 Louisville, Kentucky 40255-0666

The documents may contain confidential information. This information is intended only for the use of the individual or entity named above. If you have received this information in error, please notify the sender at 1-877-922-7379 or by calling 1-888-227-3755.



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PHYSICIAN COMPLETES THIS PAGE

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

Treating Physician Name _____ ***DEA#** _____
 National Provider ID _____
 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 _____
 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: TO BE COMPLETED BY PHYSICIAN ONLY

Patient Name _____		Patient Date of Birth _____		
Allergies _____				
Current Medications _____				
Product (Please select)	Dosage & Administration	Distribution		
<input type="checkbox"/> Vyvanse® (lisdexamfetamine dimesylate) Capsule CII	Pharmacy pick up physician must provide a prescription	<input checked="" type="checkbox"/> Pharmacy Card		
<input type="checkbox"/> Vyvanse® (lisdexamfetamine dimesylate) Chewable Tablets CII	Pharmacy pick up physician must provide a prescription	<input checked="" type="checkbox"/> Pharmacy Card		
<i>Please Note: Coverage will not exceed the maximum daily dosage as indicated within Vyvanse prescribing information. Approval for up to 12 months.</i>				
Product (Please select and complete ship product to below)	Dosage	Administration	Distribution	Refills (please select)
<input type="checkbox"/> Carbatrol® (carbamazepine) Extended-Release Capsules	<input type="checkbox"/> _____ mg	_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
<input type="checkbox"/> FOSRENOL® (lanthanum carbonate) Chewable Tablets	<input type="checkbox"/> _____ mg	_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
<input type="checkbox"/> FOSRENOL® (lanthanum carbonate) Oral Powder	<input type="checkbox"/> _____ mg	_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
<input type="checkbox"/> Lialda® (mesalamine) Delayed-Release Tablets	<input type="checkbox"/> _____ mg	_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
<input type="checkbox"/> PENTASA® (mesalamine) Controlled-Release Capsules	<input type="checkbox"/> _____ mg	_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
<input type="checkbox"/> INTUNIV® (guanfacine) Extended-Release Tablets	<input type="checkbox"/> _____ mg	_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
<input type="checkbox"/> Xiidra® (lifitegrast ophthalmic solution) 5%		_____	<input checked="" type="checkbox"/> 90-day supply	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3
Ship Product to <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Address <i>(If no selection is made, product will be shipped to Patient's Address)</i>				

Physician / Prescriber Attestation

I represent that the information above 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 meets one of the following criteria: (1) has no health care insurance and is ineligible for public or private insurance reimbursement, and has insufficient financial resources to pay for the product prescribed, or (2) has health insurance with inadequate prescription 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** _____

May we share patient protected health information with your designated contact person? Yes No

Patient Protected Health Information consists of individually identifiable health information. This includes patient demographic information, or could possibly identify the patient relating to the provision of care; and/or relates to the past, present, or future physical or mental health/condition or payment concerning a patient.

SECTION 4: PATIENT FINANCIAL INFORMATION

Number of people in your household Adults = _____ **Children (18 and under within the same household)** = _____

Total combined adjusted net income for all people in your household, including all household 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 Awards Letter

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

Is your prescription drug copay over \$50 and/or your total prescription drug deductible over \$1,000? No → If Yes, please provide proof showing your prescription copay and/or prescription deductible on your insurance company's letterhead.

What type of insurance coverage do you have? (Check all that apply)

None

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 Plan _____	Insurance Plan _____
Phone Number _____	Phone Number _____
Name of Policy Holder _____	Name of Policy Holder _____
Policy Holder Date of Birth _____	Policy Holder Date of Birth _____
Policy ID _____	Policy ID _____
Group Number _____	Group Number _____
Plan Type _____	Plan Type _____

Has your insurance plan denied coverage for this medicine? Yes No → If Yes, proof of the denial is required. Please provide with this application.

Are you a Veteran? Yes No → If Yes, have you applied for VA benefits? Yes No

SECTION 6: PATIENT CERTIFICATION

I hereby certify that I will notify Shire Cares if my financial circumstances or insurance coverage change within thirty (30) days of such change occurring. I certify that the information provided in this application is complete and accurate. I verify that the information provided in this application is complete and accurate. I further verify that I meet one of the following criteria: (1) I have no health care insurance and I am ineligible for public or private insurance reimbursement, and have insufficient financial resources to pay for the product prescribed, or (2) I have health insurance with inadequate prescription coverage for the product prescribed, including all public programs, and I have insufficient financial resources to pay for the prescribed medication. I understand that Shire Pharmaceuticals LLC reserves the right at any time and without notice to modify the application or modify or discontinue this program and related eligibility criteria.

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 _____

SECTION 7: PATIENT AUTHORIZATION

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other health care provider to disclose to Shire Pharmaceuticals LLC 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 or for the purposes of gathering information on side effects or other safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC and its agents to contact my hospital, physician or other health care provider to obtain follow-up information on any such side effects or safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC 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 authorize Shire Pharmaceuticals LLC 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 _____

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