

The COVIS Pharma Patient Assistance Program (PAP) provides medication at no cost to eligible patients. Eligible patients must be legal U.S. residents who have no insurance coverage for their COVIS Pharma medication and whose household income falls at or below 250% of the U.S. Federal Poverty Level (FPL).

## Medications Currently Available on the COVIS Pharma Patient Assistance Program

<b>Altprev<sup>®</sup> 20 mg Extended Release Tablets</b>	<b>Alvesco<sup>®</sup> Inhalation Aerosol 80 mcg/act</b>	<b>Omnaris<sup>®</sup> Nasal Spray 50 mcg/act</b>
<b>Altprev<sup>®</sup> 40 mg Extended Release Tablets</b>	<b>Alvesco<sup>®</sup> Inhalation Aerosol 160 mcg/act</b>	<b>Prilosec<sup>®</sup> 2.5mg delayed-release oral suspension</b>
<b>Altprev<sup>®</sup> 60 mg Extended Release Tablets</b>	<b>Prilosec<sup>®</sup> 10 mg delayed-release oral suspension</b>	
<b>Tudorza<sup>®</sup> Pressair<sup>®</sup> Inhaler 400 mcg</b>	<b>Zetonna<sup>®</sup> Nasal Aerosol 37 mcg/act</b>	

## Application Checklist

- Ensure all sections of the application are completed.
- Please make copies of everything you send as no documents will be returned.
- Attach a copy of the most recent Federal Tax Return for all in the household. If the patient does not file taxes, please include a letter signed by the patient stating this fact, along with other supporting documentation of income, including 1099, W2, disability/pension statement or pay stubs from two consecutive pay periods.
- If you have prescription insurance, attach a copy of the front and back of the current prescription card.
- Patient's signature and date are required on the application.
- Prescriber's signature and date are required on the application. Stamps are NOT acceptable.
- Either fax the completed application and documentation to **1-877-765-7641** or mail it to:

**COVIS Pharma Patient Assistance Program  
P.O. Box 1244  
Southampton, PA 18966**

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If the patient is eligible for assistance, the medication will be shipped to the patient's home address.

Please contact the COVIS Pharma Patient Assistance Program with any questions or for additional assistance. We can be reached at **1-844-749-1023**, Monday-Friday 9am-5pm EST.

# COVIS Patient Assistance Program

Phone: 1-844-749-1023 Fax: 1-877-765-7641



## Patient Information

Patient Name:		
Patient Address:		
City:	State:	Zip:
Patient Phone #:	Date of Birth: / /	Gender:
Last Four Digits of Social Security #:	Legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Individuals in the patient's household:	Household annual income:	
Do you have any government or private insurance coverage for the prescribed COVIS Pharma medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No
List any known allergies:		
List any known conditions:		
List all current medications:		

### AUTHORIZATION FOR PAP PARTICIPATION AND DISCLOSURE OF PATIENT INFORMATION:

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the COVIS Patient Assistance Program ("PAP") as determined by COVIS Pharma GmbH. ("COVIS") or third parties contracted by COVIS. I agree that COVIS does not have any obligation to provide PAP services to me and I waive all liability of COVIS and its third-party affiliates in the provision of PAP services. I understand that by completing this form, I am not guaranteed eligibility to receive medication at no cost from the PAP. In the event I am eligible for the PAP, I acknowledge that this assistance is temporary and may be asked to reapply at designated intervals as determined by COVIS. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP services will no longer be provided. I agree that I will not seek reimbursement for the requested medication from any government program or third-party insurer. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes.

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the COVIS Patient Assistance Program, COVIS Pharmacy

GmbH., its affiliates, or contracted third parties for the following purposes: (i) to determine eligibility for the COVIS PAP, (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, and (iii) to administer and maintain the high quality of the PAP. I understand that once the PAP receives my health information, it may communicate with my health care providers and insurers to determine PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the PAP (should I qualify I understand that I may cancel this authorization at any time by writing to the COVIS Patient Assistance Program as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the PAP receives and processes my cancellation request, the PAP will not use my health information going forward. I understand that cancelling the Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 10 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the COVIS PAP and will no longer be protected by the Health Insurance and Portability Act.

**Patient Authorization:**

**Date:**

# COVIS Patient Assistance Program

Phone: 1-844-749-1023 Fax: 1-877-765-7641



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Prescriber Information

Prescriber Name:
Prescriber Address:
City: _____ State: _____ Zip: _____
Office Phone #: _____ Office Fax #: _____
Office Contact Name:
State License #:
State where Licensed: _____ NPI #: _____

## Prescription Information

Drug/ Strength	Instructions	QTY	Refills

I certify that the information provided in this application is complete and accurate to the best of my knowledge, that the product ordered hereunder is medically indicated for this patient, and that I will be supervising the patient's treatment. I understand and certify that all units of any product that may be shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party (including, but not limited to, Medicare and any other governmental programs) shall be charged for such product. Additionally, no units of this product will be submitted for Medicare, Medicaid or any public or private third-party reimbursement, or returned for credit. I understand eligibility under this program is subject to the COVIS Patient Assistance Program's ("PAP") approval and the patient's continuing compliance with all eligibility requirements, as set by COVIS Pharma GmbH. ("COVIS"). I agree to allow the PAP or its authorized agent(s) to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the program and the patient's receipt of any product(s) provided to him or her through the program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient.

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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