

# 2002 DIRECTORY

OF PRESCRIPTION DRUG

**PATIENT ASSISTANCE PROGRAMS**

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**P/RMA**

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## INTRODUCTION

We're proud to present this Directory of Patient Assistance Programs that PhRMA member companies offer to ensure that their medicines are made available to those who can't afford to purchase them. A number of our companies have pledged that no patient in need of their medicines will do without them.

Our companies have long been worldwide leaders not only in pharmaceutical innovation, but also in philanthropic initiatives—and their long-standing patient assistance programs have been especially helpful. The Directory lists the companies that conduct these programs and the medicines that are covered. It also describes how to request assistance. The application process and eligibility vary for each company.


The programs have become increasingly popular. In 2001, more than 3.5 million patients received prescription medicines through these programs, up from 1.1 million in 1997. Almost 10 million prescriptions, with a wholesale value of about \$1.5 billion, were filled, up from about 2 million in 1997.

While patient assistance programs are essential, they're not a substitute for expanded public access to life-saving, cost-effective medicines, particularly for seniors. That's why PhRMA and its member companies continue their strong support for prompt action by Congress to provide a prescription drug benefit for Medicare beneficiaries.

Our companies are committed to their patient assistance programs, but Congress must act now to expand the access of seniors and the disabled to medicines that help and heal patients.

For the most current information on company patient assistance programs, please check our website at [www.phrma.org](http://www.phrma.org). **For additional copies of this directory, please call (800) 762-4636.**

Sincerely,



Alan F. Holmer  
President and CEO  
PhRMA

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## ABBOTT LABORATORIES

### *Name Of Program*

Patient Assistance Program

### *Contact Information*

Abbott Laboratories  
Patient Assistance Program  
200 Abbott Park Road, D31C, J23  
Abbott Park, IL 60064-6163  
(800) 222-6885

### *Product(s) Covered By Program*

Most Abbott Laboratories  
pharmaceutical products

### *Eligibility*

Abbott Laboratories patient assistance program is available to outpatients who do not have insurance reimbursement for prescriptions and are not eligible for governmental assistance programs (i.e., Medicaid, ADAP).

### *Other Program Information*

The licensed prescribers office contacts Abbott Laboratories to request an application on the behalf of a patient. An application is sent to the prescriber for completion. Upon receipt of a completed application we will send the prescriber notification regarding the patient's eligibility. If approved, medication will only be shipped to the prescriber's office.

## AGOURON PHARMACEUTICALS, INC.

### *Name Of Program*

Agouron Patient Assistance Program

### *Contact Information*

Patient Assistance Program  
(888) 777-6637

### *Product(s) Covered By Program*

VIRACEPT® (nelfinavir mesylate), RESCRIPTOR® (delavirdine mesylate)

### *Eligibility*

Eligibility is determined on a case-by-case basis and takes into consideration an individual's circumstances. Potential applicant or representative may contact the PAP at (888) 777-6637 between 9 am - 6 pm EST. Applications are mailed to the physician's office.

### *Other Program Information*

Once eligibility is determined, a monthly supply is sent to the physician's office. Enrollees must re-enroll every four months.

## ALZA PHARMACEUTICALS

### *Name Of Program*

Indigent Patient Assistance Program

**Contact Information**

Indigent Patient Assistance Program  
ALZA Pharmaceuticals  
1250 Bayhill Drive, Suite 300  
San Bruno, CA 94066  
(800) 577-3788

**Product(s) Covered By Program**

Bicitra, Ditropan, Ditropan XL, Elmiron, Mycelex, Neutra-Phos, Neutra-Phos-K, PolyCitra, PolyCitra-K, Urispas

**Eligibility**

Eligibility is determined by ALZA Pharmaceuticals and is based on patient’s insurance status and income level. Patients must be ineligible for any other third-party reimbursement or support program to apply for the Indigent Patient Assistance Program.

**Other Program Information**

The physician must request an Indigent Patient Assistance application from ALZA Pharmaceuticals.

**AMGEN, INC.**

**Name Of Program**

SAFETY NET® Program

**Contact Information**

Amgen SAFETY NET®  
(800) 272-9376

**Product(s) Covered By Program**

EPOGEN® (Epoetin alfa),

Aranesp™ (Darbepoetin alfa),  
Neupogen® (Filgrastim)

**Eligibility**

Amgen’s SAFETY NET® Program is designed to assist those patients who are medically indigent (patients may be uninsured or underinsured). Eligibility is based on patient’s insurance status and income level. To enroll, a patient’s healthcare provider should contact the Amgen SAFETY NET® Program at (800) 272-9376. Epogen® is for patients on dialysis only.

**Other Program Information**

Providers apply on behalf of the patient. Any dialysis center, physician, hospital, community pharmacy (except Epogen®) or home dialysis supplier may sponsor a patient by applying to the program on his or her behalf. The program is based on a 12-month patient year rather than on a calendar year. Phone/faxed or written applications are acceptable for program enrollment.

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**Name Of Program**

SAFETY NET® Foundation

**Contact Information**

SAFETY NET® Foundation  
(866) 546-3738 (866-KINERET)

**Product(s) Covered By Program**

Kineret™ (Anakinra)

**Eligibility**

The SAFETY NET® Foundation is designed to assist those patients who are medically indigent. Eligibility is based on patient’s insurance status and income level. To enroll, a patient or provider should contact the SAFETY NET® Foundation.

**Other Program Information**

The patient or their health care provider may enroll the patient in the SAFETY NET® Foundation. The program is based on a 12-month patient year rather than on a calendar year. Phone-in, faxed or written applications are acceptable for program enrollment.

**ASTRAZENECA**

**Name Of Program**

AstraZeneca Foundation Patient Assistance Program

**Contact Information**

Patient Assistance Program  
AstraZeneca Foundation  
P.O. Box 15197  
Wilmington, DE 19850-5197  
(800) 424-3727

**Product(s) Covered By Program**

ACCOLATE® (zafirlukast) Tablets, ARIMIDEX® (anastrozole) Tablets, ATACAND® (candesartan cilexetil) Tablets, ATACAND HCT™ (candesartan cilexetil-hydrochlorothiazide) Tablets, CASODEX®

(bicalutamide) Tablets, EMLA® Cream (lidocaine 2.5% and prilocaine 2.5%), ENTOCORT™ EC (budesonide modified release capsule), LEXXEL® (enalapril maleate-felodipine ER) Tablets, NEXIUM™ (esomeprazole magnesium) Capsules, NOLVADEX® (tamoxifen citrate) Tablets, PLENDIL® (felodipine ER) Tablets, PRILOSEC® (omeprazole) Capsules, PULMICORT RESPULES™ (budesonide inhalation suspension), PULMICORT TURBOHALER® (budesonide inhalation powder), SEROQUEL® (quetiapine fumarate) Tablets, TENORETIC® (atenolol and chlorthalidone) Tablets, TONOCARD® (tocainide HCl), TOPROL-XL® (metoprolol succinate) Extended Release Tablets, ZESTORETIC® (lisinopril and hydrochlorothiazide) Tablets, ZESTRIL® (lisinopril) Tablets, ZOLADEX® (goserelin acetate implant), ZOMIG® (zolmitriptan) Tablets

**Eligibility**

Patient applications are evaluated on a case-by-case basis by the AstraZeneca Foundation. Eligibility is based on income level/assets and absence of outpatient private insurance, third-party coverage, or participation in a public program. Income eligibility is based upon multiples of the U.S. poverty level adjusted for household size.

Patients approved into the Patient Assistance Program should receive their shipment of product within 3-4 weeks. They will not receive an acceptance letter. However, patients and their physicians will receive a denial letter if the patient does not meet the financial guidelines of the Patient Assistance Program.

#### ***Other Program Information***

If approved, a three-month supply of the medication is sent directly to the patient's home or other designated location from the mail-order fulfillment pharmacy. Refills can be written by the physician. With the shipment, patient receives instructions on how to request next supply of medication.

Patient/family members/physician can obtain application forms from the AstraZeneca Foundation by calling (800) 424-3727. Physicians also can obtain a packet of applications from their AstraZeneca sales representative. Application forms can also be obtained from the AstraZeneca website:

<http://www.astrazeneca-us.com/pap/>

Reapplication is required every 12 months. A reapplication is automatically sent to enrolled patients.

Enrollment in the program requires a valid Social Security Number.

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#### ***Name Of Program***

FOSCAVIR® Assistance and Information on Reimbursement (FA.I.R.)

#### ***Contact Information***

State and Federal Associates  
1101 King Street  
Alexandria, VA 22314  
(800) 488-FAIR (3247)  
(703) 683-2239 (fax)

#### ***Product(s) Covered By Program***

FOSCAVIR® (foscarnet sodium) Injection

#### ***Eligibility***

If the patient is not covered for outpatient prescription drugs under private insurance or a public program, the patient's income must fall below the level selected by the company. If the patient has insurance coverage for outpatient prescription drugs, he or she may be eligible for assistance with deductibles or maximum benefit limits. Eligibility is determined by the company based on income information provided by the physician.

#### ***Other Program Information***

Referral must be made by the physician.

### **AVENTIS PASTEUR**

#### ***Name Of Program***

Indigent Patient Program

#### ***Contact Information***

Customer Account Management  
Aventis Pasteur  
Discovery Drive  
Swiftwater, PA 18370-0187  
(800)-VACCINE (800-822-2463)

#### ***Product(s) Covered By Program***

IMOVAX® Rabies, rabies vaccine; IMOGAM® Rabies-HT, rabies immune globulin (human) (USP); TheraCys® BCG live intravesical (Note: IMOVAX® and IMOGAM® Rabies-HT are provided on a post-exposure basis only)

#### ***Eligibility***

Determined on a case-by-case basis. Limited to those individuals who have been identified as indigent, uninsured, and ineligible for Medicare and Medicaid; is not eligible for other programs offered by the state, county or city; the patient is a U.S. resident; patient's household income is below federal poverty guidelines. Physician must waive all fees associated with treating the patient and certify product will not be sold, traded, or used for any other purpose but to treat the patient applying for assistance.

#### ***Other Program Information***

Aventis Pasteur reserves the right to modify or discontinue the Indigent Patient Program at any time for any reason. An application form must be completed, call (800) VACCINE to receive an application. Rabies—The physician

needs to specify the quantity of IMOGAM® Rabies needed for patient (in mL) as well as the number of doses of IMOVAX® Rabies, along with the patient's age and weight. TheraCys®—Six doses are provided for one induction course of therapy. Aventis Pasteur does provide, under the program, for a full course of therapy—induction and maintenance—which may be as high as 11 doses (six doses for induction plus as many as five doses for maintenance) at the physician's discretion.

### **AVENTIS PHARMACEUTICALS**

#### ***Name Of Program***

Aventis Pharmaceuticals Patient Assistance Program

#### ***Contact Information***

Aventis Pharmaceuticals Patient Assistance Program  
P.O. Box 759  
Somerville, NJ 08876  
(800) 221-4025

#### ***Product(s) Covered By Program***

Allegra, Allegra D, Amaryl, Arava, Azmacort Inhalation Aerosol, Bentyl, Cantil, Carafate Tablets and Suspension, Claforan, Combipatch, DDAVP Injection, Intranasal and Tablets, Hiprex, Nasacort AQ Nasal Spray, Nasacort Nasal Spray, Nilandron, Penetrex Tablets, Tilade Inhaler

**Eligibility**

This program is designed to provide prescription medication, free of charge, to patients who qualify. Aventis will provide product to legal U.S. residents who do not have or qualify for any government or private prescription drug coverage. Additionally, the patient’s total annual household income must fall below the Aventis Poverty Level.

**Other Program Information**

Application forms can be obtained through Aventis and completed by both the physician and patient. A brand name prescription must be attached to every application. Up to a three-month supply of requested product is shipped to the physician’s office to be dispensed to approved patients. A new application and prescription is required for reorder. Proof of income is required for initial enrollment and annually thereafter.

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**Name Of Program**

Lovenox Patient Assistance Program (PAP)

**Contact Information**

Lovenox Patient Assistance Program (PAP)  
2211 Sanders Road NTB7  
Northbrook, IL 60067  
(888) 632-8607  
(888) 875-9951 (fax)

**Product(s) Covered By Program**

Lovenox (enoxaparin sodium) injection

**Eligibility**

This program is designed to identify if the patient is eligible for Lovenox through private insurance coverage, individual medication programs, and or government-funded sources. Aventis will provide Lovenox free of charge under the following qualifications. Participants must be U.S. residents, their annual household income must fall below the Aventis Poverty Guidelines, and they must have no insurance coverage for Lovenox. This program is available for outpatients only.

**Other Program Information**

Enrollment forms can be obtained from accessing the Internet link <http://www.lovenox.com/discharge/outpatient.htm> or calling (888) 632-8607. Participants seeking Lovenox free of charge are required to complete a Patient Assistance Application. Signatures from both the prescribing physician and patient are required. Additionally, a prescription for no more than a 3-month supply must accompany every application. Once approved, product will be shipped to either the physician’s office or a hospital outpatient pharmacy for dispensing. If Lovenox is requested for more than 3 months a new prescription is required for each reorder. Proof

of income is required for initial enrollment and annually thereafter.

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**Name Of Program**

PACT+ (Providing Access to Cancer Therapy)

**Contact Information**

PACT+  
100 Grandview Road, Suite 210  
Braintree, MA 02184  
(800) 996-ONCO (6626)  
(800) 996-6627 (fax)  
ePACT@access2health.com  
(E-mail)

**Product(s) Covered By Program**

Anzemet, Taxotere

**BAYER CORPORATION  
PHARMACEUTICAL  
DIVISION**

**Name Of Program**

Bayer Indigent Patient Program

**Contact Information**

Bayer Indigent Program  
P.O. Box 29209  
Phoenix, AZ 85038-9209  
To qualify patients, call  
(800) 998-9180  
(800) 468-0894, ext. 2765

**Product(s) Covered By Program**

Most Bayer pharmaceutical prescription medications used as recommended in prescribing information

**Eligibility**

Patient must be a U.S. resident. Physician must certify patient is not eligible for, or covered by, government-funded reimbursement or insurance program for medication; patient is not covered by private insurance; and patient’s household income is below federal poverty-level guidelines. Physician must indicate condition for which drug is to be prescribed and certify that drug will be used for indicated use only. Physician must agree to follow patient through therapy. All applications are subject to a case-by-case evaluation by Bayer Corporation.

**Other Program Information**

Patient/physician can qualify over the phone by calling (800) 998-9180. If all information needed is obtained over the phone, approval or denial is given immediately. If patient is approved, an application is generated and sent to the physician’s office for signatures.

**BERLEX  
LABORATORIES, INC.**

**Name of Program**

Berlex Patient Assistance Program

**Contact Information**

Berlex Laboratories, Inc.  
Patient Assistance Program  
PO Box 1000, M2/1-5  
Montville, NJ 07045-1000  
(888) 237-5394, option 6, option 1  
(973) 305-3545 (fax)

**Product(s) Covered By Program**

Betapace, Betapace AF, Climara, Quinaglute

**Eligibility**

To be accepted into the Berlex Patient Assistance Program, a patient must meet the following criteria: 1) must be a US citizen; 2) must be ineligible for any public or private health insurance, including Medicare and Medicaid and any other state or private programs and have an annual gross family income of \$20,000 or less. (Annual Gross Family Income includes salary, Social Security, disability payments, pension benefits, unemployment, etc. and must include spouse's income if married); 3) or, eligible for Medicare but ineligible for prescription coverage and must have an annual gross family income of \$15,000 or less; and, 4) must be under the care of a doctor/prescriber who has prescribed Betapace®, Betapace AF®, Quinaglute® Dura-Tabs® or Climara® as medically appropriate for the patient applying for assistance.

**Other Program Information**

To apply, the doctor/prescriber's office should call the Berlex toll-free number: (888) 237-5394, option 6, option 1, between 9 am - 5 pm EST. Completed applications will be reviewed and approved by the Berlex Patient

Assistance Program. If the patient is eligible, the doctor/prescriber's office will receive a three-month supply of medication usually within a week to 10 days. For further information, please call the Berlex Patient Assistance Program.

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**Name Of Program**

Betaseron Foundation

**Contact Information**

The Betaseron Foundation  
P.O. Box 221349  
Charlotte, NC 28222-3149  
(800) 948-5777

**Product(s) Covered By Program**

Betaseron

**Eligibility**

A confirmed diagnosis of multiple sclerosis. Patient must be a U.S. resident and complete an application that will be verified periodically.

**Other Program Information**

The patient or caregiver may call The Betaseron Foundation at (800) 948-5777 prior to completing an application with any questions about the application process. Complete the Patient Information and Assignment of Benefits forms. Verification of annual household income is also required. A copy of the most recent federal tax return is preferred, along with verification of any Social Security benefits received. The physician who is

responsible for the patient's ongoing care should complete the Physician Information form. Both patient and physician information must be returned to the Foundation. All applicants and their physicians will be notified in writing of the eligibility determination. All information submitted to The Foundation will remain confidential. Support begins once an application is approved; it is not retroactive. Program recipients may be required to pay a program participation fee for the Betaseron provided through the Foundation. This program participation fee varies based on a patient's financial situation, but will not exceed \$25 per month. Eligibility for continuation in the program will be verified periodically, and all applications must be renewed annually.

**BIOGEN, INC.**

**Name Of Program**

Avonex Access Program<sup>SM</sup>

**Contact Information**

MS Active Source<sup>SM</sup>  
(800) 456-2255

**Product(s) Covered By Program**

AVONEX® (Interferon beta-1a)

**Eligibility**

Eligibility is based on patient's insurance status and income level.

**BOEHRINGER  
INGELHEIM  
PHARMACEUTICALS, INC.**

**Name Of Program**

Boehringer Ingelheim Cares Foundation, Inc.

**Contact Information**

Boehringer Ingelheim Cares Foundation, Inc.  
c/o ESI/SDS  
P.O. Box 66555  
St. Louis, MO 63166-6773  
(800) 556-8317 (for information and form)

**Product(s) Covered By Program**

AGGRENOX®, ATROVENT®, CAFECIT®, CATAPRES-TTS®, COMBIVENT®, FLOMAX®, MICARDIS®, MOBIC®, and VIRAMUNE®. All products covered for FDA-approved indications only.

**Eligibility**

Eligibility to be determined solely by Boehringer Ingelheim Cares Foundation. Patient must be a U.S. citizen ineligible for public, private or other third party coverage for prescription drugs. Patient must meet established financial criteria.

**Other Program Information**

All requests are reviewed and approved on a case-by-case basis. Application form, (patient and physician information required), prescription and patient's income

documentation are required. Maximum of up to three months supply may be provided per request. Complete financial reapplication is required annually. Renewal requests within the same year require only the application form and a prescription.

Program is subject to change without notice. Current program specifics can be obtained by calling (800) 556-8317.

## **BRISTOL-MYERS SQUIBB COMPANY**

### ***Name Of Program***

Bristol-Myers Squibb Patient Assistance Foundation, Inc.

### ***Contact Information***

Bristol-Myers Squibb Patient Assistance Foundation, Inc.  
P.O. Box 4500  
Princeton, NJ 08543-4500  
Mailcode P25-37  
(800) 332-2056  
(609) 897-6859 (fax)

### ***Product(s) Covered By Program***

Many Bristol-Myers Squibb pharmaceutical products

### ***Eligibility***

This program is designed to provide temporary assistance to patients with a financial hardship who are not eligible for prescription drug coverage through Medicaid or any other public or

private health program. Patients who meet the program's eligibility criteria are provided BMS products free of charge.

### ***Other Program Information***

Physicians and other health care professionals who are interested in enrolling a patient should call the toll-free number above to request an application form.

## **CENTOCOR INC.**

### ***Name Of Program***

Remicade® Patient Assistance Program

### ***Contact Information***

Remicade® Patient Assistance Program  
P.O. Box 221709  
Charlotte, NC 28222-1709  
(866) 489-5957  
(866) 489-5958 (fax)  
(8:30 am - 8:00 pm ET)

### ***Product(s) Covered By Program***

Remicade® (infliximab, recombinant)

### ***Eligibility***

The Remicade Patient Assistance Program is a service to provide product to low-income patients legally residing in the United States when patients meet certain financial need qualifications. When patients qualify, they may be provided with up to six months of product at a time.

### ***Other Program Information***

Health care providers, patients, patients' guardians, and social workers may submit applications for product. All applications will require the signature of the patient or guardian as well as the health care provider. The program only provides product for eligible patients. If the patient meets the eligibility criteria, product is shipped directly to the provider's office or to the site of care.

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### ***Name Of Program***

Centocor Solutions™ Program for Retavase®

### ***Contact Information***

Centocor Solutions Program  
1800 Robert Fulton Drive  
Suite 300  
Reston, VA 20191  
(800) 331-5773  
(800) 777-7562 (fax)  
(9:00 am - 5:00 pm ET, Mon.-Fri.)

### ***Product(s) Covered By Program***

Retavase® (reteplase, recombinant)

### ***Eligibility***

Centocor Solutions Program will replace Retavase used to treat patients who meet specific medical and financial criteria and lack third-party insurance.

### ***Other Program Information***

Upon request, an application with a cover letter will be sent to the provider of service to be completed and returned with required documentation. If the patient meets the eligibility requirements, the product will then be shipped directly to the pharmacy of the hospital where the patient was treated.

## **CIBA PHARMACEUTICALS**

(Please see Novartis Pharmaceuticals, page 26)

## **DUPONT PHARMACEUTICALS COMPANY**

(Please see Bristol-Myers Squibb Company, page 10)

## **EISAI INC.**

### ***Name Of Program***

Aricept® (donepezil HCl) Patient Assistance Program

### ***Contact Information***

Aricept® Patient Assistance Program  
(800) 226-2072

### ***Product(s) Covered By Program***

Aricept® (donepezil HCl) 5mg and 10 mg tablets

### ***Eligibility***

Eisai Inc. and Pfizer Inc have developed the Aricept Patient

Assistance Program for those U.S. residents without prescription drug coverage through either public or private insurance. Aricept® will be provided free of charge to patients who meet the following criteria:

Patient has no insurance or other third-party payer prescription drug coverage, including Medicaid coverage or Medicare managed care coverage. Patient's annual income must fall within a predetermined range. Patient must be diagnosed by a physician as having mild to moderate dementia of the Alzheimer's type.

**Other Program Information**

Patient must requalify after 90-day initial supply.

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**Name Of Program**

Aciphex® (rabeprazole sodium)  
Patient Assistance Program

**Contact Information**

Aciphex® Patient Assistance  
Program  
(800) 523-5870

**Product(s) Covered By Program**

Aciphex® (rabeprazole sodium)  
20 mg tablets

**Eligibility**

Eisai Inc. and Janssen Pharmaceutica, Inc. have developed the

Aciphex® Patient Assistance Program for those U.S. residents without prescription drug coverage through either public or private insurance. Aciphex® will be provided free of charge to patients who meet the following criteria:

Patient has no insurance or other third-party payer prescription drug coverage, including Medicaid coverage or Medicare managed care coverage. Patient's annual income must fall within a predetermined range. Program specialists determine eligibility for each patient. The program requests that physicians not charge patients beyond insurance coverage for professional services. Patient must be diagnosed by a physician as having a medical need for Aciphex®.

**Other Program Information**

If necessary, patient must requalify after initial supply.

**ELAN  
PHARMACEUTICALS, INC.**

**Name Of Program**

Elan Pharmaceuticals Prescription  
Assistance Program

**Contact Information**

Call (866) 347-3185 for current  
program information

**FUJISAWA  
HEALTHCARE, INC.**

**Name of Program**

Prograf® Patient Assistance  
Program

**Contact Information**

Prograf® Patient Assistance  
Program  
c/o Quorum Consulting, Inc.  
P.O. Box 221644  
Chantilly, VA 20153-1644  
(800) 477-6472

**Product(s) Covered By Program**

Prograf® capsules (tacrolimus)

**Eligibility**

The Prograf® Patient Assistance Program is designed to assist patients who have no health insurance and limited financial resources. To be eligible for the program, patients must meet income, residency and insurance criteria. Please call the Prograf® Patient Assistance Program for assistance in determining patient eligibility. If the patient meets the criteria, hotline staff will send a pre-filled application to the physician.

**Other Program Information**

If approved, the patient will receive two 90-day shipments during the enrollment period. If continued therapy is needed beyond six months, the patient must reapply to the program.

• • •

**Name Of Program**

Protopic® Patient Assistance  
Program

**Contact Information**

Protopic® Patient Assistance  
Program  
c/o Quorum Consulting, Inc.  
P.O. Box 221644  
Chantilly, VA 20153-1644  
(800) 477-6472

**Product(s) Covered By Program**

Protopic® Ointment (tacrolimus  
ointment)

**Eligibility**

The Protopic® Patient Assistance Program is designed to assist patients who have no health insurance and limited financial resources. To be eligible for the program, patients must meet income, residency, and insurance criteria. Please contact the Protopic® Patient Assistance Program for assistance in determining patient eligibility. If the patient meets the criteria, hotline staff will send a pre-filled application to the patient or physician.

**Other Program Information**

If approved, the patient will receive two shipments during the enrollment period. If continued therapy is needed beyond 12 months, the patient must reapply to the program.

## **GENENTECH, INC.**

### ***Name Of Program***

Genentech Patient Assistance Program

### ***Contact Information***

Genentech, Inc.  
1 DNA Way, MS-13A  
South San Francisco,  
CA 94080-4990  
(800) 879-4747  
(650) 225-1366 (fax)

### ***Product(s) Covered By Program***

Activase® (Alteplase), Herceptin® (Trastuzumab), Nutropin® (somatropin), Nutropin AQ® (somatropin), Nutropin Depot®, Protropin® (somatrem), Rituxan® (Rituximab) and TNKase™ (Tenecteplase)

### ***Eligibility***

For consideration of eligibility for the Genentech Patient Assistance Program, the patient must not be eligible for public or private insurance reimbursement and must meet income restrictions and medical eligibility.

### ***Other Program Information***

For reimbursement assistance for Nutropin, Nutropin AQ, Nutropin Depot or Protropin, the physician must contact the Single Point of Contact (SPCO) Reimbursement Department at (800) 545-0498.

For reimbursement assistance for Activase or TNKase, an application

must be completed by the treating hospital. For further information and assistance, the hospital may contact the Genentech Reimbursement Hotline at (800) 530-3083.

For reimbursement assistance for Herceptin or Rituxan, an application must be completed and signed by the treating physician. For further information and assistance the physician may contact the Genentech Reimbursement Hotline at (800) 530-3083.

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### ***Name Of Program***

Genentech Endowment for Cystic Fibrosis

### ***Contact Information***

Genentech Endowment for Cystic Fibrosis  
4828 Parkway Plaza Blvd., Suite 220  
Charlotte, NC 28217-1969  
(800) 297-5557 (Monday through Friday, 9 am - 5 pm, ET)  
(704) 357-0036 (fax)  
www.genentechcfendowment.org

### ***Product(s) Covered By Program***

Pulmozyme® (dornase alfa)

### ***Eligibility***

The Endowment offers three programs designed to meet the special needs of the cystic fibrosis (CF) population. If you are uninsured, the Endowment offers an Uninsured Patient Program. You may also be eligible for this

program if you have insurance but the policy has certain coverage limitations, such as no drug benefit. If you have insurance, you may qualify for assistance through the Copayment Assistance Program. This program assists qualifying patients with Pulmozyme out-of-pocket copayment requirements based upon a sliding scale adjusted for income, family size, and other pre-established criteria. Both uninsured and underinsured patients may benefit from the Premium Assistance Program. This program assists qualifying patients with insurance premium costs. Assistance levels are based upon a sliding scale.

### ***Other Program Information***

Patients may be enrolled in only one program at a time. In addition to the programs described above, the Endowment assists qualifying patients with the purchase of nebulizers and compressors for Pulmozyme administration.

## **GENETICS INSTITUTE, INC.**

### ***Name Of Program***

The BENEFIX Reimbursement and Information Program

### ***Contact Information***

(888) 999-2349

### ***Product(s) Covered By Program***

Benefix™ Coagulation Factor IX (recombinant)

### ***Eligibility***

The program is designed to provide temporary assistance to patients who meet the pre-determined eligibility criteria. Eligible patients must be without prescription drug coverage from a third-party payer. Patients who meet the eligibility criteria are eligible for a period of 90 days, at which time they must requalify for the program.

### ***Other Program Information***

Application forms are sent to physicians who are treating specific patients who may qualify for the program. Application forms must be signed by the patient and physician prior to returning to the program at 1101 King Street, Suite 600, Alexandria, VA 22314.

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### ***Name Of Program***

Neumega® Access Program

### ***Contact Information***

The Neumega® Access Program  
(888) NEUMEGA (638-6342)

### ***Product(s) Covered By Program***

Neumega® (oprelvekin)

### ***Eligibility***

For uninsured and underinsured patients who have limited financial resources.

### **Other Program Information**

Reimbursement specialists provide assistance to physicians, nurses, office managers, pharmacists and patients with insurance reimbursement, such as information on billing and coding. Service staff will also provide individualized help with claims filing and preauthorization requests and provide support in challenging claim denials.

## **GENZYME CORPORATION**

### **Name Of Program**

Ceredase® / Cerezyme® Access Program (CAP Program)  
Established by the Genzyme Charitable Foundation, Inc.

### **Contact Information**

Wytske Kingma, M.D.  
Medical Affairs  
Genzyme Corp.  
One Kendall Square  
Cambridge, MA 01239-1562  
(800) 745-4447, ext. 17808

### **Product(s) Covered By Program**

Ceredase® (alglucerase injection),  
Cerezyme® (imiglucerase for injection)

### **Eligibility**

Based on financial and medical need. Must be uninsured and lack the financial means to purchase the drug. In order to maintain eligibility, patients and their families are expected to continue exploring alternative funding

options with the Genzyme Case Management Specialist. These options include private insurance, government programs and/or charitable sources.

### **Other Program Information**

The CAP Program is considered a temporary funding program.

## **GILEAD SCIENCES, INC.**

### **Name Of Program**

Gilead Sciences Reimbursement Support and Assistance Program

### **Contact Information**

Gilead Sciences Reimbursement Support and Assistance Program  
(800) 226-2056  
(800) 216-6857 (fax)  
(9:00 am - 5:00 pm ET)

### **Product(s) Covered By Program**

VIREAD™ (tenofovir disoproxil fumarate), VISTIDE® (cidofovir injection), DAUNOXOME® (daunorubicin citrate liposome injection)

### **Eligibility**

Gilead Sciences Reimbursement Support and Assistance Program is designed to assist both insured and uninsured patients in receiving reimbursement for VIREAD, VISTIDE or DAUNOXOME. To determine eligibility for this program, physicians or patients may request a Patient Assistance Program application for VIREAD,

VISTIDE or DAUNOXOME and mail or fax the completed form to Gilead Sciences Reimbursement Support and Assistance Program.

### **Other Program Information**

The program offers insurance claims assistance, referrals for financial support, referrals to AIDS service agencies. Support specialists consult with insured patients and their physicians regarding prior authorization or third-party insurance claims, contact insurance companies on behalf of patients and contact patients and physicians to offer appeal procedures.

## **GLAXOSMITHKLINE**

### **Name Of Program**

Glaxo Wellcome Patient Assistance Program

### **Contact Information**

Glaxo Wellcome Inc.  
Patient Assistance Program  
P.O. Box 52185  
Phoenix, AZ 85072-2185  
(800) 722-9294  
(800) 750-9832 (fax)

### **Additional Program Information Can Be Found At:**

www.ipp.gsk.com  
Program materials may also be ordered by health professionals through this website.

### **Product(s) Covered By Program**

All marketed Glaxo Wellcome prescription products used in an outpatient setting

### **Eligibility**

The Glaxo Wellcome Patient Assistance Program has been established to provide short-term assistance to eligible patients until alternative funding can be found. All Glaxo Wellcome medications used in an outpatient setting are available. The Glaxo Wellcome Patient Assistance Program is a philanthropic activity of Glaxo Wellcome. The Program is intended to serve patients who do not have drug benefits through private insurance or government-funded programs. The Patient Assistance Program is not intended to replace government programs.

### **Other Program Information**

The Glaxo Wellcome Patient Assistance Program not only provides medications but also provides reimbursement services to help patients locate other payment sources that may provide more comprehensive health care coverage.

Health care advocates should fill out the application form and call (800) 722-9294 to enroll patients. Completed applications are reviewed against the company's established criteria on a case-by-case basis. Income eligibility is

based upon multiples of the federal poverty level adjusted for household size. The only fee that patients are required to pay to participate in the program is a nominal pharmacy copayment. Program benefits for outpatient products are provided through pharmacies. Injectable products are provided to the health care provider via direct product shipment.

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#### **Name Of Program**

SmithKline Beecham Foundation  
Access to Care

#### **Contact Information**

SmithKline Beecham Foundation  
Access to Care  
c/o Express Scripts/SDS  
P.O. Box 2564  
Maryland Heights, MO 63043-8564  
(800) 546-0420  
(800) 729-4544

#### **Product(s) Covered By Program**

Amoxil, Augmentin, Avandia, Bactroban, Compazine, Coreg, Dyazide, Paxil, Relafen, Requip and Tagamet. Hycamtin is covered under a separate Access to Care program. (See next listing.)

#### **Eligibility**

The patient has a medical condition for which the medication is needed. The patient has represented that his/her annual household income is under

\$25,000. The cost of the patient's prescription is not fully covered by medical insurance, government aid (e.g., Medicare) or private programs, and in the opinion of the treating physician, the cost of this therapy may impose significant hardship on the patient or result in noncompliance with treatment.

#### **Other Program Information**

Application forms can be obtained by calling (800) 546-0420. The patient and the physician fill out the application and should be sure to include all information. Incomplete forms will be returned. Both patient and physician must sign the form. The physician indicates the strength and dosage of the requested product on the prescription. A separate form and prescription must be sent for each individual. All requests must be submitted on an original SB Foundation Access to Care form. Photocopies of the application will not be accepted under any circumstances. Reapplications are required. The product will be sent to the patient's home and will require a signature upon delivery. Third-party requests will not be honored.

The SmithKline Beecham Foundation reserves the right to eliminate or modify the use of its Access to Care certificates and make such changes at any time without notice.

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#### **Name Of Program**

Oncology Access to Care Program

#### **Contact Information**

The Oncology Access to Care  
Hotline  
(800) 699-3806

#### **Product(s) Covered By Program**

Hycamtin (topotecan HCl)

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#### **Name Of Program**

Orange Card<sup>SM</sup>

#### **Contact Information**

Your local GlaxoSmithKline (GSK) sales representative or call the GSK Customer Response Center at (888) 825-5249

#### **Product(s) Covered By Program**

All outpatient GSK prescription products are included. GlaxoSmithKline's OTC products and in-patient prescription medicines are not covered.

#### **Eligibility**

The Orange Card is for seniors and the disabled who: are enrolled in Medicare, have annual incomes below \$30,000 single/\$40,000 couples (Alaska: \$33,000 single/\$44,000 couple; Hawaii: \$30,000 single/\$40,000 couple) and are without public or private insurance coverage for prescription medicines.

#### **Other Program Information**

Enrollment in this program is free and only requires that patients fill out an easy application form. Physicians do not have to sign or adjudicate the application. Patient eligibility is self-reported and verified by an independent third party. Once participants receive their card, they may use it to obtain significant savings on all outpatient GSK products.

GlaxoSmithKline guarantees a 25% savings off our list price, which GlaxoSmithKline provides directly to Orange Card participants.\* The Orange Card is designed so participants will realize average savings of 30% off the usual price they pay for outpatient GSK medicines.\* These savings could exceed 40% depending on the pharmacy's usual and customary price and the prescribed GSK medicines.\*

GSK supports a Medicare prescription drug benefit. Until then, the Orange Card is GlaxoSmithKline's way to help.

\*Orange Card participants will receive direct savings on their purchase of GSK outpatient prescription medicines equal to 25% of our list price to wholesalers (as reported by First DataBank, Inc.). Participating pharmacies will charge Orange Card holders no more than a maximum charge, established by the Orange Card administrator less the amount of GSKs point-of-sale savings,

plus a dispensing fee paid by the Orange Card holder. Because of variations in pharmacy prices, actual savings to Orange Card participants on each prescription will vary. However, GSK expects participants to realize average savings of 30% off the price individuals without prescription medicine coverage would usually pay for GSK medicines at their pharmacy. In some cases, savings could be 40% or greater depending on the pharmacy's usual and customary price for the prescribed GSK medicine.

## **HOECHST MARION ROUSSEL, INC.**

(Please see Aventis Pharmaceuticals, page 5)

## **IMMUNEX CORPORATION**

### ***Name of Program***

Immunex Patient Assistance Program

### ***Contact Information***

Immunex Patient Assistance Program  
(800) 321-4669  
(800) 944-3184 (fax)

### ***Product(s) Covered By Program***

LEUKINE® (sagramostim), NOVANTRONE® (mitoxantrone for injection concentrate), THIOPLEX® (thiotepa for injection)

### ***Eligibility***

Eligibility is based on criteria that include the patient's insurance

status and income level. Patients must be ineligible for any other third-party reimbursement or support program to apply for the Immunex Patient Assistance Program. Eligibility criteria are subject to change without notice.

### ***Other Program Information***

The physician applies on behalf of the patient. All requests are reviewed and approved on a case-by-case basis. Application form, prescription, and patient's income documentation are required. Once eligibility has been verified, up to a three-month supply of the prescribed medication(s) is sent directly to the the prescriber's office for distribution to the patient.

Program is subject to change without notice. Current program specifics can be obtained by calling (800) 321-4669.

## **JANSSEN PHARMACEUTICA**

### ***Name of Program***

Janssen Patient Assistance Program

### ***Contact Information***

Janssen Patient Assistance Program  
P.O. Box 221857  
Charlotte, NC 28222-1857  
(800) 652-6227  
(888) 526-5168 (fax)

### ***Product(s) Covered By Program***

Janssen's medical prescription products

### ***Eligibility***

Program will ensure that Janssen's prescription products [Duragesic® (fentanyl transdermal), Nizoral® Tablet (ketoconazole tablet), Sporanox® (itraconazole)] will be free of charge to any persons who meet specific medical criteria and lack financial resources and third-party insurance necessary to obtain treatment. Program specialist determines eligibility for each patient. Janssen requests that physicians not charge patients beyond insurance coverage for professional services.

### ***Other Program Information***

One or two months' supply available; varies by product.

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### ***Name Of Program***

Aciphex® Patient Assistance Program

### ***Contact Information***

Aciphex® Patient Assistance Program  
P.O. Box 220458  
Charlotte, NC 28222-0458  
(800) 523-5870  
(800) 526-6651 (fax)  
(Please see Eisai Inc. on page 7 for complete program information.)

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### ***Name of Program***

Reminyl Reach Patient Assistance Program

### ***Contact Information***

Reminyl Reach Patient Assistance Program  
P.O. Box 222197  
Charlotte, NC 28222-2197  
(866) 736-4695  
(888) 526-4870 (fax)

### ***Products Covered***

Reminyl (galantamine HBr) Tablets and Oral Solution

### ***Eligibility***

Program will ensure that Reminyl (galantamine HBr) is made free of charge to any persons without prescription drug coverage who meet pre-established financial criteria.

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### ***Name Of Program***

The Risperdal Patient Assistance Program and The Risperdal Reimbursement Support Program

### ***Contact Information***

Janssen Cares  
The Risperdal Patient Assistance Program  
P.O. Box 222098  
Charlotte, NC 28222-2098  
(800) 652-6227  
Monday through Friday  
(9:00 am - 5:00 pm E.T.)  
(888) 526-5170 (fax)

### **Eligibility**

Program will ensure that all RISPERDAL® (risperidone) is made available free of charge to any persons who lack financial resources and third-party insurance necessary to obtain treatment. Reimbursement specialist determines eligibility for each patient. Janssen requests that physicians not charge patients beyond insurance coverage for professional services.

The Risperdal Reimbursement Support Program is designed to answer physicians' and patients' questions and solve problems related to Risperdal reimbursement as efficiently and quickly as possible.

### **LEDERLE LABORATORIES**

(Please see Wyeth Pharmaceuticals, page 46)

### **ELI LILLY AND COMPANY**

#### **Name Of Program**

Lilly Cares

#### **Contact Information**

Lilly Cares Program Administrator  
Lilly Cares  
P.O. Box 230999  
Centreville, VA 20120  
(800) 545-6962

#### **Product(s) Covered By Program**

Most Lilly prescription products and insulins (except controlled

substances) are covered by this program. Gemzar® is covered under a separate program.

#### **Eligibility**

Patients must be U.S. residents. Eligibility is determined on a case-by-case basis in consultation with each prescribing physician. Eligibility is based on the patient's inability to pay and lack of third-party drug payment assistance, including insurance, Medicaid, government-subsidized clinics, and other government, community, or private programs. Inpatients and those who can obtain drug reimbursement from any source are not eligible. Requests for replacement drugs cannot be honored. Medications are provided directly to the physician for dispensing to the patient. Quantity of supply is dependent upon type of product being prescribed. All Lilly medications must be used as recommended in product labeling.

#### **Other Program Information**

Forms to qualify a patient for the program will be provided to the physician. On this form, the physician is requested to provide prescription information, including signature and DEA number, and to confirm the patient's ineligibility for other forms of outpatient drug coverage. Additionally, the patient is requested to provide pertinent information and state financial need.

Subsequent request for same patient requires another application and restatement of medical and financial need. Program guidelines may be subject to change.

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#### **Name Of Program**

LillyAnswers<sup>SM</sup>

#### **Contact Information**

(877) 795-4559 (877-RX-LILLY)  
www.lillyanswers.com.

#### **Product(s) Covered By Program**

All Lilly retail products will be offered, except controlled substances as well as products not distributed by retail pharmacies. The program offers many of those medications most commonly prescribed to seniors, such as Evista for osteoporosis, Humulin and Humalog for diabetes, Prozac for depression and Zyprexa for schizophrenia.

#### **Eligibility**

Patient must be 65 or older or people with disabilities enrolled in Medicare. Patient must be at or below 200 percent federal poverty level (less than \$18,000 per year for individuals and \$24,000 for married couples.) Patient can have no other form of prescription drug coverage.

#### **Other Program Information**

Patient will receive a short application form, which they will fill

out and return with copies of their most recent tax return and Medicare card. Once the application is received and eligibility confirmed, a LillyAnswers card will be mailed to the patient. Once a patient is enrolled in the LillyAnswers program, they will be covered for 12 months. After 12 months, patients will have to requalify through the application process.

The LillyAnswers program offers a flat \$12 administrative fee for a 30-day supply of any retail distributed Lilly drug, excluding controlled substances as well as products not distributed by retail pharmacies. The program also offers patient education and disease management tools designed to help seniors best manage their medical condition and easy guidelines for seniors, physicians, and pharmacists.

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#### **Name Of Program**

Gemzar® Patient Assistance Program

#### **Contact Information**

Gemzar® Reimbursement Hotline  
(888) 443-6927 (888-4-GEMZAR)

#### **Product(s) Covered By Program**

Gemzar® (gemcitabine hydrochloride)

### **Eligibility**

Applications for the program are available by calling the toll-free Gemzar Hotline. Applicants determined to be eligible based on program income criteria will be approved on the basis of these additional criteria: no medical insurance, and ineligible for any programs with a drug benefit provision, including Medicaid, third-party insurance, Medicare, and all other programs have denied coverage for Gemzar in writing, and all appeals have been exhausted.

### **THE LIPOSOME COMPANY, INC.**

(Please see Elan Pharmaceuticals, page 12)

### **MERCK & CO., INC.**

#### ***Name Of Program***

The Merck Patient Assistance Program

#### ***Contact Information***

The Merck Patient Assistance Program—Health care professionals with prescribing privileges may call (800) 994-2111

#### ***Product(s) Covered By Program***

Most Merck products. Requests for vaccines and injectables are not accepted, with the exception of requests for anti-cancer injectable products.

### **Eligibility**

The Merck Patient Assistance Program is designed to provide temporary assistance to patients who have no access to any insurance coverage for prescription medications and are truly unable to afford prescription medications. The patient must have exhausted all options for prescription benefits and coverage including: private insurance, HMOs, Medicaid, Medicare, state pharmacy assistance programs, Veteran's Assistance, and any other social service agency support. Patients must also reside in the United States and have a U.S. treating physician. Completed applications are reviewed on a case-by-case basis.

#### ***Other Program Information***

Each application must be completely filled out and signed by both the prescriber and the patient and be mailed with an original, signed, dated prescription with the prescriber's name, address, professional designation, and a DEA or state license number.

Completed applications are reviewed for eligibility on a case-by-case basis. Once eligibility has been verified, up to a three-month supply of the prescribed medication(s) is sent to the patients home address unless otherwise indicated on the application. Medications are labeled for the patient.

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#### ***Name Of Program***

The Merck Patient Assistance Program for Aggrastat® Reimbursement Support and Patient Assistance Services for Aggrastat®

#### ***Contact Information***

The Merck Patient Assistance Program for Aggrastat® Health care professionals or patients may call (877) 810-0595

#### ***Product(s) Covered By Program***

Aggrastat® (tirofiban HCI)

#### ***Eligibility***

Financially disadvantaged patients may be eligible for assistance through the Merck Patient Assistance Program for Aggrastat. This program is designed to help cover the cost of Aggrastat for eligible patients who meet the following criteria: must demonstrate financial need, must not have coverage through an insurance provider, and must not be eligible for any third-party insurance or government-sponsored programs, including Medicare and Medicaid.

Alternative sources of coverage must be explored before applying to the Merck Patient Assistance Program for Aggrastat. Reimbursement is not guaranteed to all applicants.

### **Other Program Information**

Hospital administrators can call the Merck Patient Assistance Program for Aggrastat at (877) 810-0595. Patient assistance experts will assist with the application process to determine eligibility. This program also offers reimbursement counseling for patients and providers to assist with any payor questions.

Health care professionals who participate in this program are under no obligation to prescribe Aggrastat or any other product manufactured by Merck & Co., Inc. The Merck Patient Assistance Program for Aggrastat may be discontinued or modified at any time, without notice.

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#### ***Name Of Program***

The SUPPORT™ Program for Crixivan® Reimbursement Support and Patient Assistance Services for Crixivan®

#### ***Contact Information***

The SUPPORT™ Program for Crixivan® Health care professionals or patients may call (800) 850-3430

#### ***Product(s) Covered By Program***

Crixivan® (indinavir sulfate)

**Eligibility**

The SUPPORT™ program assists patients who are prescribed Crixivan® and are uncertain of their insurance coverage, in locating payment sources for Crixivan®. Free product is provided to those uninsured patients who qualify, and for whom no alternative source of coverage can be identified. Patients must also reside in the United States and have a U.S. treating physician. All applications are reviewed on a case-by-case basis. Product is shipped to the prescriber’s office for distribution to the patient. Medicine is labeled for the patient.

**NOVARTIS  
PHARMACEUTICALS**

**Name Of Program**

Novartis Patient Assistance Program

**Contact Information**

Novartis Pharmaceuticals  
Patient Assistance Program  
P.O. Box 8609  
Somerville, NJ 08876  
(800) 277-2254

**Product(s) Covered By Program**

Certain single source and/or life-sustaining products. Controlled substances are not included.

**Eligibility**

Patients must be U.S. residents. The Patient Assistance Program provides temporary assistance to patients who are experiencing financial hardship and who have no prescription drug insurance. Patients are required to complete an application along with their physicians and return it for evaluation.

**Other Program Information**

Patient applications are evaluated on a case-by-case basis.

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**Name Of Program**

Novartis Care Card<sup>SM</sup>

**Contact Information**

Call (866) 974-CARE (2273) for more information about the Novartis Care Card<sup>SM</sup> program.

**ORGANON INC.**

**Name Of Program**

Remeron Indigent Patient Program

**Contact Information**

Local Organon sales representative

**Product(s) Covered By Program**

Remeron® (mirtazapine)

**Eligibility**

Patients must be U.S. residents. Eligibility is determined on a case-by-case basis and is based on a patient’s inability to pay and who are not eligible to receive these drugs through any other third-party drug reimbursement program, i.e., Medicaid, local or federal agency programs, Blue Cross/Blue Shield, private insurance programs and private foundations. Inpatients and those who can obtain drug reimbursement from other sources are not eligible.

**Other Program Information**

Forms to qualify a patient for the program will be provided to the physician. On this form, the physician is requested to provide prescription information, including their signature and DEA number and to confirm the patient’s ineligibility for other forms of outpatient drug coverage. The patient is requested to provide the pertinent information and state financial need.

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**Name Of Program**

“Gold Star” Fertility Assistance Program

**Contact Information**

Local Organon sales representative

**Product(s) Covered By Program**

Follistim® (follitropin beta for injection), Follistim Antagon Kit

**Eligibility**

Patients must be U.S. residents. Eligibility is determined on a case-by-case basis and is based on a patient’s inability to pay and who are not eligible to receive these drugs through any other third-party drug reimbursement program, i.e., Medicaid, local or federal agency programs, Blue Cross/Blue Shield, private insurance programs and private foundations. Inpatients and those who can obtain drug reimbursement from other sources are not eligible.

**Other Program Information**

Forms to qualify a patient for the program will be provided to the physician. On this form, the physician is requested to provide prescription information, including their signature and DEA number and to confirm the patient’s ineligibility for other forms of outpatient drug coverage. The patient is requested to provide the pertinent information and state financial need.

## **ORTHO BIOTECH PRODUCTS, L.P.**

### ***Name Of Program***

PROCRIline™

### ***Contact Information***

PROCRIline™

1250 Bayhill Drive, Suite 300

San Bruno, CA 94066

(800) 553-3851

(800) 987-5572 (fax)

9:00 am - 8:00 pm ET

### ***Product(s) Covered By Program***

PROCRI® (Epoetin alfa) for non-dialysis use, LEUSTATIN® (cladribine) Injection

### ***Eligibility***

Program will ensure that PROCRI and/or LEUSTATIN is made available to any persons who meet specific medical criteria and lack financial resources and third-party coverage necessary to obtain treatment. A reimbursement specialist determines eligibility.

### ***Other Program Information***

Patient eligibility application forms are available by accessing the 800 number (800) 553-3851 or on PROCRIline.com (<http://www.procritline.com>). This call can help determine if a patient is eligible to enroll in the program or is eligible for an alternative program if other sources of funding are identified.

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### ***Name of Program***

Ortho Biotech Products, L.P.

Reimbursement Solutions

### ***Contact Information***

Ortho Biotech Reimbursement Solutions

1250 Bayhill Drive, Suite 300

San Bruno, CA 94066

(800) 609-1083

(800) 987-5572 (fax)

### ***Products Covered***

DOXIL® (doxorubicin hydrochloride liposome injection)

### ***Eligibility***

Program will ensure that DOXIL® is made available to any persons who meet specific medical criteria and lack financial resources and third party coverage necessary to obtain treatment. A reimbursement specialist determines eligibility.

### ***Other Program Information***

Patient eligibility applications forms are available by accessing the 800 number (800) 609-1083. This call can help determine if a patient is eligible to enroll in the program or is eligible for an alternative program if other sources of funding are identified.

## **ORTHO DERMATOLOGICAL**

### ***Name Of Program***

Ortho Dermatological Patient Assistance Program

### ***Contact Information***

Ortho Dermatological Patient Assistance Program

Ortho-McNeil Patient Assistance Program

P.O. Box 938

Somerville, NJ 08876

(800) 797-7737

### ***Product(s) Covered By Program***

Prescription products prescribed according to approved labeled indications and dosage regimens

### ***Eligibility***

Patients should not have insurance coverage for prescription medication. Patients should not be eligible for other sources of drug coverage; they need to have applied to public sector programs and been denied. Must meet program financial criteria.

### ***Other Program Information***

Health care practitioner should request an application form. The completed form must be accompanied by a signed and dated prescription. Medication will be sent to the health care practitioner for dispensing to the patient.

## **ORTHO-McNEIL PHARMACEUTICAL, INC.**

### ***Name Of Program***

Ortho-McNeil Patient Assistance Program

### ***Contact Information***

Ortho-McNeil Patient Assistance Program

P.O. Box 938

Somerville, NJ 08876

(800) 797-7737

### ***Product(s) Covered By Program***

Prescription products prescribed according to dosage regimens

### ***Eligibility***

Patients should not have insurance coverage for prescription medication. Patients should not be eligible for other sources of drug coverage; they need to have applied to public sector programs and been denied. Must meet program financial criteria.

### ***Other Program Information***

Health care practitioner should request an application form. The completed form must be accompanied by a signed and dated prescription. Medication will be sent to the health care practitioner for dispensing to the patient.

## **OTSUKA AMERICA PHARMACEUTICAL, INC.**

### ***Name Of Program***

RxMAP Prescription Medication Assistance Program

### ***Contact Information***

RxMAP  
P.O. Box 29043  
Phoenix, AZ 85038-9988  
(800) 242-7014

### ***Product(s) Covered By Program***

Pletal® (cilostazol) Tablets

### ***Eligibility***

The Prescription Medication Assistance Program (RxMAP) will provide Pletal to individual patients who have special needs due to short-term financial hardships. Patients will have to meet specific eligibility requirements in order to receive this short-term assistance. Eligibility is based on federal poverty level and no prescription drug coverage.

### ***Other Program Information***

All inquiries should contact RxMAP at (800) 242-7014

## **PARKE-DAVIS**

(Please see Pfizer, page 30)

## **PFIZER INC**

### ***Name Of Program***

Pfizer Prescription Assistance

### ***Contact Information***

Pfizer Prescription Assistance  
P.O. Box 230970  
Centreville, VA 20120  
(800) 646-4455

### ***Product(s) Covered By Program***

Most Pfizer outpatient products with chronic indications are covered by this program. Aricept®, Diflucan®, Geodon and Zithromax® are covered by separate programs.

### ***Eligibility***

Any patient that a physician is treating as indigent is eligible. Patients must have incomes below \$12,000 (single) or \$15,000 (family). Patients must not be receiving or be eligible for third-party or Medicaid reimbursements for medications. No copayment or cost-sharing is required by the patient.

### ***Other Program Information***

Specific forms are not required. The physician must write a letter on his or her letterhead to Pfizer stating that the patient meets income criteria and is uninsured for pharmaceuticals and enclose a prescription for the desired product. The letter must be signed by the prescribing physician. Products are shipped to the physician for redistribution to the patient. Products are supplied to the physician in stock packages, usually 100 tablets or capsules. It may take up to four weeks to

receive the product. Refills are obtained through physician resubmission of request. Pfizer reserves the right to limit enrollment of patients.

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### ***Name Of Program***

Parke-Davis Patient Assistance Program

### ***Contact Information***

The Parke-Davis Patient Assistance Program  
P.O. Box 1058  
Somerville, NJ 08876  
(908) 725-1247

### ***Product(s) Covered By Program***

Accupril, Accuretic, Dilantin, Estrostep, FemHRT, Lipitor, Loestrin, Neurontin, and Zarontin

### ***Eligibility***

Patients must not be eligible for other sources of drug coverage and must be deemed financially eligible based on company guidelines and physician certification.

### ***Other Program Information***

Physicians should request an application form from their Parke-Davis Sales Representative. The completed form, accompanied by a signed and dated prescription, should be mailed to the address above. Up to a three-month supply will be delivered to the physician for dispensing to the patient.

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### ***Name Of Program***

Sharing the Care

### ***Requests Should Be Directed To***

Sharing the Care  
Pfizer Inc  
235 E. 42nd Street  
New York, NY 10017-5755  
(800) 984-1500

### ***Product(s) Covered By Program***

Certain Pfizer single-source products

### ***Eligibility***

The program, a joint effort of Pfizer, the National Governors' Association, and the National Association of Community Health Centers, works solely through community, migrant, and homeless health centers that are funded under section 330(e), 330(g), or 330(h) of the Public Health Service Act and that have an in-house pharmacy. The program includes the participation of more than 375 health centers throughout the United States. To be eligible to participate in Sharing the Care, the patient must be registered at a participating health center, must not be covered by any private insurance or public assistance covering pharmaceuticals, must not be Medicaid-enrolled, and must have a family income that is equal to or below the federal poverty level. Pfizer reserves the right to limit enrollment of patients and health centers.

**Other Program Information**

Product is dispensed to patient at health center pharmacy.

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**Name Of Program**

Diflucan® and Zithromax® Patient Assistance Program

**Contact Information**

Diflucan® and Zithromax® Patient Assistance Program  
(800) 869-9979

**Product(s) Covered By Program**

Diflucan® (fluconazole) and Zithromax® (azithromycin) for MAC prophylaxis and treatment

**Eligibility**

Patient must not have insurance or other third-party coverage, including Medicaid, and must not be eligible for a state’s AIDS drug assistance program. Patient must have an income of less than \$25,000 a year without dependents, or less than \$40,000 a year with dependents.

**Other Program Information**

Physicians should call the Diflucan® and Zithromax® Patient Assistance Program and explain the patient’s situation to the Patient Assistance Specialist. The specialist will then send a short qualifying form that requests insurance status, income information, and the amount of Diflucan®

or Zithromax® the patient will require. The form must be completed, signed, a prescription attached, and returned to the Patient Assistance Program in the envelope provided.

The Program staff will determine whether the patient is eligible for free Diflucan® or Zithromax® on the same day the form is received. A letter will be sent notifying the physician of the patient’s eligibility or ineligibility. It may take up to three weeks from the placement of the first call to the delivery of the product to physicians. Pfizer reserves the right to limit enrollment of patients.

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**Name of Program**

Geodon Patient Assistance Program

**Contact Information**

Geodon Patient Assistance Program  
P.O. Box 52119  
Phoenix, AZ 85072  
(866) 443-6366

**Products Covered**

Geodon

**Eligibility**

Patients who are at or below 200 percent of the federal poverty level and have no access to other forms of public or private reimbursement for pharmaceuticals.

**Other Program Information**

Physicians should call the Geodon Patient Assistance Program to speak with a Patient Assistance Specialist.

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**Name of Program**

Pfizer for Living Share Card Program

**Contact Information**

(800) 717-6005

**Product(s) Covered by Program**

Most Pfizer prescription medicines available at a retail pharmacy

**Eligibility**

Patients who meet all of the following requirements are eligible: enrolled in Medicare, have no prescription drug coverage and are not eligible for Medicaid or any other publicly-funded prescription benefit program, have a gross income of less than \$18,000 per year, or \$24,000 if filing jointly

**Other Program Information**

The Share Card Program is free and requires no fees to join.

The Share Card Program offers many health benefits to enrollees. First, the Share Card itself enables patients to pay \$15 for up to a 30-day supply of every Pfizer prescription they have. Second, the program offers live operator

assistance for potential applicants and enrollees. Third, applicants have the opportunity to request easy-to-read health information on a variety of health topics.

Most Pfizer medicines are covered.

In order to apply, an applicant must submit the application, a copy of his or her Medicare card as well as a copy of his or her proof of income (2001 tax return or the Social Security Benefit Verification Statement—Form SSA1099).

Potential enrollees may call (800) 717-6005 to ask questions about the Share Card Program.

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**Name Of Program**

Aricept® Patient Assistance Program (Please see Eisai Inc. on page 7 for complete program information.)

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**Name Of Program**

(A Participant in) the Arkansas Health Care Access Program

**Contact Information**

Ms. Pat Keller  
Program Director  
Arkansas Health Care Access Foundation  
P.O. Box 56248  
Little Rock, AR 72215  
(800) 950-8233, (501) 221-3033

**Product(s) Covered By Program**

Most Pfizer prescription products are covered

**Eligibility**

Must be an Arkansas resident to qualify. Eligible individuals are certified by the Arkansas Local County Department of Human Services as being Arkansas residents below the federal poverty guidelines, who do not have health insurance benefits and do not qualify for any government entitlement programs. No copayment or cost-sharing is required from the patient. Physician must waive his or her fee for the initial visit. This program does not apply to individuals during hospital inpatient stays.

**Other Program Information**

Physicians should contact the Arkansas Health Care Access Foundation for further information.

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**Name Of Program**

(A Participant in) the Kentucky Health Care Access Program

**Contact Information**

Mr. J. Scott Judy  
Executive Vice President  
Health Kentucky, Inc.  
12700 Shelbyville Road  
Louisville, KY 40243  
(800) 633-8100  
(502) 254-4214  
(502) 254-5117 (fax)  
healthky@pop.net (e-mail)

**Product(s) Covered By Program**

Most Pfizer prescription products are covered

**Eligibility**

Must be a Kentucky resident to qualify. Eligible individuals are certified by the Kentucky Cabinet for Health Services as Kentuckians below the federal poverty standards who do not have health insurance benefits and do not qualify for any government entitlement programs. No copayment or cost-sharing is required from the patient. Physician must waive his or her fee. This program does not apply to individuals during hospital inpatient stays.

**Other Program Information**

Physicians should contact Health Kentucky, Inc. for further information.

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**Name Of Program**

(A Participant in) Commun-I-Care

**Contact Information**

Mr. Ken Trogdon  
Director  
Commun-I-Care  
P.O. Box 12054  
Columbia, SC 29211  
(800) 763-0059, (803) 933-9183

**Product(s) Covered By Program**

Most Pfizer prescription products are covered

**Eligibility**

Eligible individuals must be South Carolina residents. Individuals are certified by Commun-I-Care as below the federal poverty line and not covered by any government entitlement programs. No copayment or cost-sharing is required from the patient. Physician must waive his or her fee.

**Other Program Information**

Physicians should contact Commun-I-Care for further information.

**PHARMACIA CORPORATION**

**Name of Program**

Pharmacia Patients in Need® (PIN) Foundation

**Contact Information**

Pharmacia Patients in Need Foundation  
P.O. Box 52059  
Phoenix, AZ 85072  
(800) 242-7014  
(480) 314-7163 (fax)

**Product(s) Covered By Program**

Numerous products

**Eligibility**

Patient does not qualify for outpatient prescription drugs under private insurance, a public program, or other assistance that pays in whole or in part for prescription drugs; patient's income falls below a percentage of the Federal Poverty Level (FPL).

**Other Program Information**

Enrollment begins with the physician, patient, or patient advocate calling the program at (800) 242-7014, between 9 am - 8 pm ET, Monday through Friday. Have the application with the attached certificate in hand. Program specialists will collect specific information about the patient, the drug therapy prescribed, and will ask for the certificate number. If approved, a 30-day supply of the prescribed drug will be authorized.

The patient completes section one of the application. The physician completes section two of the application and returns it to the program, including the patient's income documentation. Both the patient (or legal guardian) and the physician are required to sign the application. The application documents the patient's eligibility for the program. Approval of the patient's enrollment will be based on current program criteria. Program eligibility secures an additional five (5) months of assistance for the patient.

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#### ***Name Of Program***

TreatFirst<sup>SM</sup>

#### ***Contact Information***

TreatFirst<sup>SM</sup>  
P.O. Box 2975  
Phoenix, AZ 85062  
(877) 744-5675  
or  
Local Pharmacia Oncology Sales  
Representative

#### ***Product(s) Covered By Program***

Aromasin® (exemestane tablets),  
Camptosar® (irinotecan),  
Celebrex® (celecoxib capsules),  
Ellence® (epirubicin), Emcyt®  
(estramustine phosphate sodium  
capsules), Idamycin® (idarubicin),  
Zinecard® (dexarazoxane)

#### ***Eligibility***

Patient does not have insurance coverage for products included in TreatFirst and patient's income falls below a percentage of the Federal Poverty Level (FPL).

#### ***Other Program Information***

The physician or patient can call TreatFirst<sup>SM</sup> at (877) 744-5675 to initiate the application process. A Reimbursement Counselor will conduct a preliminary assessment of eligibility over the phone. If the patient appears to qualify, a 30-day supply of the prescribed drug will be authorized and an application with a pharmacy card is generated and sent to the patient.

The physician will be asked to complete the Physician Information portion of the application. Patients will need to complete the Patient portion of the application (including financial and insurance information). Proof of income is required. Both the patient (or legal guardian) and the physician are required to sign the application. The application documents the patient's eligibility for the program. Approval of the patient's enrollment will be based on current program criteria. Program eligibility secures an additional five (5) months of assistance for the patient.

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#### ***Name Of Program***

Pharmacia Bridge Program<sup>TM</sup> for  
Genotropin<sup>TM</sup>

#### ***Contact Information***

Pharmacia Bridge Program for  
Genotropin  
3168 Riverport Tech Center Drive 2  
Maryland Heights, MO 63043  
(800) 645-1280

#### ***Product(s) Covered By Program***

Genotropin<sup>TM</sup>

#### ***Eligibility***

Patient does not have coverage for Genotropin under private insurance, a public program, or other assistance that pays in whole or in part for Genotropin and the patient's income falls below a percentage of the Federal Poverty Level (FPL).

#### ***Other Program Information***

The physician or patient can call The Bridge Program at (800) 645-1280 to initiate the reimbursement counseling and/or patient assistance process.

#### **PROCTER & GAMBLE PHARMACEUTICALS, INC.**

#### ***Name Of Program***

Procter & Gamble  
Pharmaceuticals Patient  
Assistance Program

#### ***Contact Information***

Procter & Gamble  
Pharmaceuticals  
c/o Express Scripts  
P.O. Box 6553  
St. Louis, MO 63166-6553  
(800) 830-9049

#### ***Product(s) Covered By Program***

Actonel, Asacol, Dantrium  
Capsules, Didronel, Macrochantin,  
Macrobid

#### ***Eligibility***

Procter & Gamble Pharmaceuticals has always tried to ensure that all patients have full access to its products. To qualify, patients should have exhausted prescription coverage through private or public insurance. Each patient's case is handled on an individual basis.

The company relies on the physician for referrals to the program. Application forms are provided by the company for the physician/patient to complete. An original prescription duly signed by the attending physician for one of the company's products is required.

#### ***Other Program Information***

The quantity of product supplied depends on the diagnosis and need, but generally a three-month supply is provided for a chronic medication. Refills require a new

prescription from the physician and a completed Refill Form. The prescription medication is sent directly to the patient. Applications are good for one year. Annually, patients must be re-screened to ensure continued eligibility.

### **RHÔNE-POULENC RORER INC.**

(Please see Aventis Pharmaceuticals, page 5)

### **ROCHE LABORATORIES, INC.**

A Division of Hoffmann-La Roche Inc. Roche Products Inc.

#### ***Name Of Program***

Roche Medical Needs Program

#### ***Contact Information***

Roche Medical Needs Program  
Roche Laboratories, Inc.  
340 Kingsland Street  
Nutley, NJ 07110  
(800) 285-4484

#### ***Product(s) Covered By Program***

Roche product line with some exceptions

#### ***Eligibility***

The Roche Medical Needs Program is designed as an interim solution for patients who lack third-party outpatient prescription drug coverage under private insurance, government-funded

programs (e.g., Medicaid, Medicare, Veterans Affairs, etc.), or private/community sources and are unable to afford to purchase our products on their own.

Roche offers the Medical Needs Program as a philanthropic endeavor to assure access to Roche products for needy patients at no charge until alternative funding can be found. The Roche Medical Needs Program is part of Roche's commitment to assure access to our products and is not intended to supplant or replace prescription drug coverage provided by third-party public or private payers.

This program is for individual outpatients who meet the Medical Needs Program criteria and is offered through licensed practitioners. The program is not intended for clinics, hospitals, and/or other institutions.

#### ***Other Program Information***

Roche Medical Needs Program forms obtained from the Medical Needs Department are required. Applications are provided only to licensed practitioners. Physicians' and patients' signatures, and a state license number, or a DEA number, if a controlled substance is requested, are required on the application. A new application form must be completed for patients requiring refills. All completed applications

will be reviewed and approved by Roche on a case-by-case basis using the established criteria of the program. Patients and providers may be requested to participate in reimbursement case management based on the product requested. Up to a three-month supply of product will be shipped directly to the licensed practitioner within two to three weeks.

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#### ***Name Of Program***

Roche Medical Needs Program for CellCept® (mycophenolate mofetil), CYTOVENE® (ganciclovir capsules), and CYTOVENE®-IV (ganciclovir sodium for injection)

#### ***Contact Information***

Roche Transplant Reimbursement Hotline  
(800) 772-5790

#### ***Product(s) Covered By Program***

CellCept® (mycophenolate mofetil), CYTOVENE® (ganciclovir capsules), and CYTOVENE®-IV (ganciclovir sodium for injection). CYTOVENE products for use with transplant patients

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#### ***Name Of Program***

Roche Medical Needs Program for FORTOVASE™ (saquinavir), INVIRASE® (saquinavir mesylate), CYTOVENE® (ganciclovir capsules), CYTOVENE®-IV (ganciclovir sodium for injection), HIVID® (zalcitabine) and VALCYTE™ (valgancyclovir HCl)

#### ***Contact Information***

HIV Therapy Assistance  
(800) 282-7780

#### ***Product(s) Covered By Program***

FORTOVASE™ (saquinavir), INVIRASE® (saquinavir mesylate), CYTOVENE® (ganciclovir capsules), CYTOVENE®-IV (ganciclovir sodium for injection), HIVID® (zalcitabine) and VALCYTE™ (valgancyclovir HCl). CYTOVENE products for use with HIV/AIDS patients

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#### ***Name Of Program***

Roche Medical Needs Program for Kytril (granisetron), Roferon®-A (Interferon alpha-2a, recombinant), Vesanoïd® (tretinoin), and Xeloda (capecitabine)

#### ***Contact Information***

Oncoline™/Hepline™  
Reimbursement Hotline  
(800) 443-6676 (press 2 or 3)

**Product(s) Covered By Program**

Roferon®-A (Interferon alpha-2a, recombinant), Kytril (granisetron), Vesanoid® (tretinoin), Xeloda (capecitabine)

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**Name of Program**

Roche Medical Needs Program for Xenical® (orlistat)

**Contact Information**

Xenicare Weight Loss Support Program  
(800) 260-7785

**SANDOZ  
PHARMACEUTICAL  
CORPORATION**

(Please see Novartis Pharmaceuticals, page 26)

**SANKYO PHARMA**

**Name Of Program**

Sankyo Pharma Open Care Program

**Contact Information**

Sankyo Pharma Open Care Program  
P.O. Box 8409  
Somerville, NJ 08876  
(866) 268-7327

**Product(s) Covered By Program**

WelChol® (colesevelam HCl)

**Eligibility**

The Sankyo Pharma Open Care Program is available to qualified patients with demonstrated medical and financial need. The program assists patients who are prescribed Sankyo products and are uncertain of their insurance coverage, in locating alternative payment sources. Free product is provided to uninsured patients who qualify and for whom no alternative source of reimbursement can be identified. Patients must reside in the United States and have a U.S. treating physician.

**Other Program Information**

The physician’s office must apply on behalf of a patient. Applications are available from Sankyo Pharma representatives or from Sankyo Pharma Open Care Program hotline—(866) 268-7327. Upon receipt and approval of a completed application, all patients will receive a supply (the amount depends on the product) of medication, which will be shipped to the physician’s office on the patient’s behalf. Patients who remain on therapy will complete reimbursement counseling to identify alternative sources of insurance. Patients without alternative sources of insurance will continue to receive free product. Periodic reviews of applications will be conducted to ensure continued eligibility.

**SANOFI-SYNTHELABO  
INC.**

**Name Of Program**

Needy Patient Program

**Contact Information**

Sanofi-Synthelabo  
Needy Patient Program  
c/o Product Information Dept.  
90 Park Avenue  
New York, NY 10016  
(800) 446-6267

**Product(s) Covered By Program**

Aralen, Danocrine, Drisdol, Kerlone, Mytelase, NegGram, pHisoHex, Plaquenil, Primaquine.

Arixtra, Hyalgan, Primacor, and Skelid eligibility determined on a financial case-by-case basis.

For Avalide, Avapro, and Plavix call (800) 736-0003.

**Other Program Information**

The physician’s office should contact the Sanofi-Synthelabo Product Information Department to apply on behalf of a patient. An application is sent to the physician’s office for completion and signature, in addition to a signed prescription. Upon receipt of completed application and prescription from physician, and upon approval of application, medication will be shipped directly to the physician’s office from the

distribution center. Each physician is allowed to enroll six patients per year. Each patient can receive a 3-month supply of medication, with an option of one refill for an additional three months supply for a total of six months medication for one year. The physician must contact Sanofi-Synthelabo’s office for the refill.

**SCHERING  
LABORATORIES/KEY  
PHARMACEUTICALS**

**Name Of Program**

Commitment to Care

**Contact Information**

For Intron A/Eulexim:  
(800) 521-7157

For Other Products:

Schering Laboratories/  
Key Pharmaceuticals  
Patient Assistance Program  
P.O. Box 52122  
Phoenix, AZ 85072  
(800) 656-9485

**Product(s) Covered By Program**

Most Schering/Key prescription drugs

**Eligibility**

The program is designed to assist those patients who are truly in need—indigent—who are not eligible for private or public

insurance reimbursement and who cannot afford treatment. Patient eligibility is determined on a case-by-case basis based upon economic and insurance criteria. Eligibility criteria are currently being reevaluated and may be subject to change.

**Other Program Information**

Physician and patient complete an application form. Application is reviewed on a case-by-case basis. Repeat requests require a new application form to be completed.

**SEARLE**

(Please see Pharmacia, page 35)

**SERONO, INC.**

**Name Of Program**

Connections for Growth

**Contact Information**

Serono Connections for Growth  
(800) 582-7989

**Product(s) Covered By Program**

Saizen® (somatropin [rDNA origin] for injection) for treatment of pediatric growth hormone deficiency

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**Name Of Program**

SeroCare<sup>SM</sup>

**Contact Information**

SeroCare<sup>SM</sup>  
100 Longwater Circle  
Norwell, MA 02061  
(800) 714-2437  
(800) 214-8698 (fax)

**Product(s) Covered By Program**

Serostim<sup>TM</sup> (human growth hormone [rDNA origin]) for treatment of AIDS wasting

**SIGMA-TAU  
PHARMACEUTICALS, INC.**

**Name Of Program**

NORD/Sigma-Tau Carnitor®  
Drug Assistance (CDA) Program

**Contact Information**

Carnitor® Drug Assistance  
Program  
c/o NORD  
P.O. Box 8923  
New Fairfield, CT 06812-8923  
(800) 999-NORD

**Product(s) Covered By Program**

Carnitor® (levocarnitine)

**Eligibility**

All applicants must be citizens or permanent residents of the United States. Eligibility is determined by medical and financial criteria and applied to a cost-share formula. A patient applying for eligibility under the CDA Program must first demonstrate having a legal prescription for Carnitor®. Second,

the applicant must prove financial need above and beyond the availability of federal and state funds, private insurance or family resources.

If an applicant is a minor or an adult dependent, NORD may request financial information of family members or guardians before determining the applicant's eligibility.

Applications must be submitted annually to determine continued medical and financial eligibility. Acceptance into the program at any time does not guarantee ongoing eligibility, nor does it mean that applicants are entitled to or will be granted benefits at a later time.

**Other Program Information**

Generally, a patient over 18 years of age may submit his or her own application. If the patient is an adult under the guardianship of another adult, or is a minor, the patient and his/her guardian or parents must jointly submit an application. Applications are reviewed throughout the year. One application per patient, per year, will be accepted. In the event of a significant change in a patient's circumstances, a second application may be considered.

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**Name Of Program**

NORD/Sigma-Tau Matulane®  
Patient Assistance Program

**Contact Information**

Matulane® Patient Assistance  
Program  
c/o NORD  
P.O. Box 8923  
New Fairfield, CT 06812-8923  
(800) 999-NORD

**Product(s) Covered By Program**

Matulane® (procarbazine hydrochloride)

**Eligibility**

All applicants must be medically eligible for Matulane by having a diagnosis of Stage III or IV Hodgkin's disease documented by the treating physician, or any other lymphomas where a physician feels a response is possible. All applicants must be a U.S. citizen or a permanent U.S. resident. All applicants must sign waivers and release of liability forms. Applicants must prove financial need above and beyond the availability of federal and state funds, private insurance or family resources.

**Other Program Information**

One application will cover the duration of the therapy regimen that is prescribed by the treating physician. This therapy is used in conjunction with certain other anticancer drugs for the treatment

of Stage III and IV Hodgkin's disease.

### **SMITHKLINE BEECHAM PHARMACEUTICALS**

(Please see GlaxoSmithKline, page 17)

### **SOLVAY PHARMACEUTICALS, INC./ UNIMED PHARMACEUTICALS, INC.**

#### ***Name Of Program***

Patient Assistance Program

#### ***Contact Information***

Solvay Pharmaceuticals, Inc./  
Unimed Pharmaceuticals, Inc.  
Patient Assistance Program  
c/o Express Scripts Specialty  
Distribution Services  
P.O. Box 66550  
St. Louis, MO 63166-6550  
(800) 256-8918

#### ***Product(s) Covered By Program***

*Solvay Pharmaceuticals, Inc:*

ACEON® (perindopril erbumine)  
Tablets 2 mg, 4 mg and 8 mg;  
CREON® MINIMICRO-  
SPHERES® (pancrelipase)  
Delayed-Release Capsules  
5, 10 and 20; ESTRATEST®  
(esterified estrogens, USP 1.25 mg  
and methyltestosterone, 2.5 mg)  
Tablets; ESTRATEST® H.S.  
(esterified estrogens USP

0.625 mg and methyltestosterone,  
1.25 mg) Tablets; LITHOBID®  
(lithium carbonate, USP)  
Tablets 300 mg; ROWASA®  
Rectal Suspension Enema  
(mesalamine) 4g/60mL unit dose.

*Unimed Pharmaceuticals, Inc:*

ANADROL® (oxymetholone)  
Tablets 50 mg; AndroGel® 1%  
(testosterone gel) CIII 2.5 g and  
5 g; MARINOL® (dronabinol)  
Capsules 2.5 mg, 5 mg and 10 mg;  
TEVETEN® (eprosartan mesylate)  
Tablets 400 mg and 600 mg

#### ***Eligibility***

The patient must be a legal U.S. resident. The patient must not have medical insurance. The patient must be medically indigent (unable to afford medication). This is determined by comparing the patient's annual household income minus out-of-pocket medical expenses to poverty guidelines established by the federal government.

#### ***Other Program Information***

Physicians apply on behalf of the patient by submitting a written request on an application form. Blank forms may be obtained by calling (800) 256-8918. Ongoing patient participation is available based on continued medical and financial need.

### **3M PHARMACEUTICALS**

#### ***Name Of Program***

Indigent Patient Pharmaceutical Program

#### ***Contact Information***

Medical Services Department  
275-6W-13, 3M Center  
St. Paul, MN 55144-1000  
(800) 328-0255  
(651) 733-6068 (fax)

#### ***Product(s) Covered By Program***

Most drug products sold by 3M Pharmaceuticals in the United States

#### ***Eligibility***

Patients whose financial and insurance circumstances prevent them from obtaining 3M Pharmaceuticals drug products considered to be necessary by their physicians. Consideration is on a case-by-case basis.

### **TAKEDA PHARMACEUTICALS AMERICA**

#### ***Name Of Program***

Patient Assistance Program

#### ***Contact Information***

Takeda Pharmaceuticals America, Inc. (TPA)  
Patient Assistance Program  
877-TAKEDA7 or (877) 825-3327

#### ***Product(s) Covered By Program***

ACTOS (pioglitazone hydrochloride)

#### ***Eligibility***

Enrollment for the Patient Assistance Program of TPA is valid for one year. The following criteria must be met for the patient to be considered: (A) The patient's annual income is evaluated against the current U.S. Department of Health and Human Services Poverty Guidelines. (B) The patient has no insurance coverage for prescriptions. (C) The patient is ineligible for government (e.g., Medicaid) or private programs that cover the cost of prescription drugs. (D) The patient is a legal citizen of the U.S. (E) A signature of both the patient and physician is required on the application form. (F) Once enrolled into the program, a completed 90-day prescription must be included with the mailer for refills. Patients will be notified that the year is up 30 days before the end of the program at which time they will have to be reenrolled into the program by a physician.

#### ***Other Program Information***

To enroll qualified patients in the Takeda Patient Assistance Program, phone (877) 825-3327. An enrollment form will then be faxed to the patient's physician.

Once the form has been filled out completely and signed by the physician and the patient, the form and a 90-day prescription for ACTOS (15, 30, or 45 mg) should be faxed to Specialty Distribution Services (SDS) at (800) 497-0928. Once the patient is approved for the program, SDS will send the patient a welcome letter with the prescription of ACTOS along with a refill mailer form for future shipments. The physician will also receive a fax regarding the patient's acceptance into the program.

**UNIMED  
PHARMACEUTICALS, INC.**  
(Please see Solvay  
Pharmaceuticals, page 44)

## **WYETH PHARMACEUTICALS**

### ***Name Of Program***

Norplant Foundation

### ***Contact Information***

The Norplant Foundation  
P.O. Box 25223  
Alexandria, VA 22314  
(703) 706-5933

### ***Product(s) Covered By Program***

The Norplant® (levonorgestrel implants) five-year contraceptive system

### ***Eligibility***

Determined on a case-by-case basis and limited to individuals who cannot afford the product and who are ineligible for coverage under private and public sector programs.

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### ***Name Of Program***

Rheumatoid Arthritis Assistance  
Foundation

### ***Contact Information***

Rheumatoid Arthritis Assistance  
Foundation  
P.O. Box 4133  
Gaithersburg, MD 20897-7808  
(888) 4ENBREL (436-2735)  
(888) 508-8083 (fax)

### ***Product(s) Covered By Program***

ENBREL® (etanercept)

### ***Eligibility***

To qualify for assistance, patients or providers should contact (800) 282-7704 and staff will screen patients for eligibility over the phone. If the patient appears to qualify, an application will be mailed directly to the patient. Eligibility criteria are subject to change without notice.

### ***Other Product Information***

The Rheumatoid Arthritis Assistance Foundation was established to improve access

to ENBREL® for patients who have limited resources. To be eligible for assistance, patients must meet the criteria set by the Foundation Board of Directors. Please call (800) 282-7704 for more information or to discuss eligibility.

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### ***Name Of Program***

Wyeth Pharmaceuticals Patient  
Assistance Program

### ***Contact Information***

Wyeth Pharmaceuticals  
Patient Assistance Program  
P.O. Box 13806  
Philadelphia, PA 19101-9649

### ***Product(s) Covered By Program***

Various products (not including schedule II, III, or IV products)

### ***Eligibility***

Limited to individuals, on a case-by-case basis, who have been identified by their physicians as "indigent," meaning:

- Low or no income
- Not covered by any third-party agency

### ***Other Product Information***

The program is accessed by physicians whose patients meet the eligibility requirements. A three-month supply of specific products is provided directly to the physician for dispensing to the patient. The patient's signature is required on the application form.

**PhARMA**

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