Reset Form

VALEANT
Pharmaceuticals North America

VALEANT PATIENT ASSISTANCE PROGRAM

P.O. Box 42886 Cincinnati, OH 45242 Phone: 1-800-511-2120 Fax: 1-513-618-0060

Healthcare Providers can apply for patient assistance online at www.RxHope.com.

PHYSICIAN INFORMATION

DEA Number _____ State License Number _____ Exp _____

Physician Name (Last, First, MI) _____ Specialty _____

Address _____

City _____ State _____ Zip Code _____ Contact _____

Telephone _____ Fax _____ Email _____

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature _____ Date _____

PRODUCT INFORMATION

☐ **8-MOP** Capsules per day: _____
(methoxsalen USP)

☐ **Ancobon Capsules,** 500 mg Capsules per day: _____
(flucytosine)

☐ **Chlordiazepoxide HCl/Clidinium Bromide 5/2.5 mg**
Capsules per day: _____

☐ **Diastat AcuDial,** 10 mg Quantity: _____
(diazepam rectal gel)

☐ **Diastat AcuDial,** 20 mg Quantity: _____
(diazepam rectal gel)

☐ **Diastat Gel,** 2.5 mg Quantity: _____
(diazepam rectal gel)

☐ **Mestinon,** 60 mg/Syrup Teaspoons per day: _____
(pyridostigmine bromide)

☐ **Mestinon Timespan Tablets,** 180 mg Tablets per day _____
(pyridostigmine bromide)

☐ **Migranal Nasal Spray** Quantity: _____
(dihyroergotamine mesylate, USP)

☐ **Mysoline,** 50mg Tablets per day: _____
(primidone)

☐ **Mysoline,** 250mg Tablets per day: _____
(primidone)

☐ **Oxsoralen Lotion** Quantity: _____
(methoxsalen USP, 1%)

☐ **Oxsoralen-Ultra Capsules** Capsules per week: _____
(methoxsalen USP)

☐ **Prostigmin Tablets,** 15 mg Tablets per week: _____
(neostigmine bromide)

☐ **Tasmar Tablets,** 100 mg Tablets per day: _____
(tolcapone)

☐ **Zelapar** Tablets per day: _____
(selegiline HCl) ODT

Patient's Diagnosis: _____

PATIENT INFORMATION

Patient Name (Last, First, MI) _____

Address _____

City _____ State _____ Zip Code _____ Gender: ☐ M ☐ F

Phone _____ Date of Birth (MM/DD/YYYY) _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Social Security # _____ Are you a U.S. resident? ☐ Y ☐ N Are you a Veteran? ☐ Y ☐ N

Number of persons in household _____ Gross Annual Household Income $ _____

Do you have any prescription coverage for the medication prescribed? ☐ Y ☐ N _____
If yes, please specify

Are you enrolled in Medicare Part D? ☐ Y ☐ N

I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I hereby authorize the Valeant Patient Assistance Program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature _____ Date _____