

Thank you for your interest in the Valeant Patient Assistance Program (Valeant PAP).

This program is designed to provide assistance and access to individuals in need of products made available through the Valeant PAP. All applications are reviewed on a case-by-case basis and there is no cost to apply. If approved, you may be able to receive product through this program for up to one year, as long as you remain eligible and a valid prescription remains on file.

You may be eligible for the program if you:

- Are a legal United States resident
- Have a valid prescription from a licensed U.S. healthcare professional for a product made available through the Valeant PAP
- Do not have insurance coverage for the prescribed Valeant product
 - Patients with Medicare Part B or Medicare Part D coverage may request an appeal to be evaluated for Valeant PAP eligibility if they meet all other program guidelines
- Are being treated as an outpatient
- Meet the pre-defined eligibility requirements and total annual household income requirements

For full eligibility requirements, please visit ValeantPAP.com.

Participating Valeant Pharmaceuticals companies include:



BAUSCH+LOMB



Ortho | Dermatologics



Salix
PHARMACEUTICALS



VALEANT
Pharmaceuticals North America LLC

Submitting an Application

Patient Instructions

1. Complete the Patient Information and Insurance Information Sections on page 1.
2. **Read and sign the Patient Authorization and Certification on page 2.**
3. Have your prescriber complete pages 3 and 4 and sign Prescriber Certification on page 4.
4. If applicable, attach a copy of your medical and prescription insurance cards.

Prescriber Instructions

1. Complete Product Information and Prescriber Information on pages 3 and 4.
2. **Sign Prescriber Certification on page 4.**
3. Attach original valid prescription(s) with physician signature. Stamped signatures are not allowed for controlled substances.

Special note: New York prescribers must submit the patient's prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank, if applicable for your state. **Faxed prescriptions must be faxed from the prescriber's office.**

4. Have patient complete pages 1 and 2.

Mail or fax the completed application form, requested documentation, and signed original prescription to:

VALEANT PATIENT ASSISTANCE PROGRAM
P.O. BOX 429303, Cincinnati, OH 45242-9303
PHONE 833-862-VPAP (833-862-8727)
FAX 866-777-5705

For questions about the program or how to complete this application, please contact the Valeant Patient Assistance Program at 833-862-VPAP (833-862-8727), Monday through Friday, 8:00 AM to 5:00 PM Eastern Time.

Patient Assistance Program Application



To be completed by the Patient

Please print clearly. All items must be completed or application will be returned. If something does not apply, please write N/A.

- Complete the Patient Information and Insurance Information Sections on page 1.
- Read and sign the Patient Authorization and Certification on page 2.**
- Have your prescriber complete pages 3 and 4 and sign Prescriber Certification on page 4.
- If applicable, attach a copy of your medical and prescription insurance cards.

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1 Patient Information (*Required)

*First Name _____ *Last Name _____
*Street Address _____
*City _____ *State _____ *ZIP Code _____
*Primary Phone # _____ Home Mobile Secondary Phone # _____ Home Mobile
Best Time to Call _____ *Is it ok to have a pharmacist contact you? Yes No
*Social Security or Green Card # _____ *U.S. Resident Yes No Gender M F
Email _____ *Date of Birth _____
*Check Number of People in Household (include self) 1 2 3 4 5 6+ *Annual Household Income \$ _____

2 Insurance Information (Select all that apply and, if applicable, attach a copy of your medical and prescription insurance cards)

I Do Not Have Health Insurance (if checked, go to Section 3)

Private Insurance (such as HMO or PPO) Does your policy include Prescription Drug Coverage? Yes No
Insurer Name _____ Insurer Phone # _____
Cardholder Name _____ Cardholder date of birth _____
Relationship to Cardholder _____ Group ID # _____
Policy ID # _____ Rx BIN # _____ Rx PCN # _____

Medicare (select all that apply)

Medicare Part A? Yes No **Medicare Part B?** Yes No **Medicare Part C** (Medicare Advantage)? Yes No
Insurer Name _____
Insurer Phone # _____ Medicare Policy ID # _____
Medicare Part D? Yes No If you received a denial letter for Low Income Subsidy, please attach a copy with your application.
Part D Plan Name _____ Part D Plan Phone # _____
Part D Policy ID # _____ Rx BIN # _____ Rx PCN # _____

Other Government Insurance

Medicaid? Yes No Veterans Affairs (VA) Benefits? Yes No
State Elderly Drug Assistance? Yes No Other State/Federal Patient Assistance Program? Yes No
Plan Name _____ Phone # _____
Policy ID # _____ Rx BIN # _____ Rx PCN # _____
Any other benefit program that helps pay for prescription drugs? Yes No

To be completed by the Patient

3 Patient Authorization and Certification (Patient must read and sign below)

I hereby consent to allow Valeant Pharmaceuticals, and its affiliates, agents, and contractors, including the administrator of the Valeant PAP, the dispensing pharmacy or distributor of Valeant products (collectively, "Valeant") to use and/or disclose the information in this form and my dispensing information to any third party engaged to assist Valeant in the administration of the Valeant PAP. I understand that this information will be used to determine my eligibility for participation in the Valeant PAP and to administer the program, except as may be required or permitted by applicable law, and that Valeant reserves the right at any time for any reason to contact me and to request additional information. I, the applicant named below, understand that I am providing 'written instructions' to Valeant and its vendor, Triplefin LLC, under the Fair Credit Reporting Act authorizing Triplefin LLC on behalf of Valeant to obtain information from my credit profile or other information from Experian Health or any other credit reporting agency. I authorize Valeant and its partnered provider, Triplefin LLC, to obtain such information solely for determining financial qualifications for the Valeant PAP. I understand that I must affirmatively agree to the terms in this notice by signing below to proceed in the PAP financial screening process. **I understand that I am not required to give my consent, and that while my refusal will not impact my health care providers' treatment of me, if I do not provide consent, Valeant will not be able to evaluate my eligibility for the Valeant PAP.** I understand that the information I provide may be subjected to re-disclosure and will no longer be protected by HIPAA. I understand that Valeant and any third party engaged to assist in the administration of the program has the right to verify my eligibility, including the right to audit any information provided by me or my physician. I understand that the parties disclosing or receiving my data pursuant to this authorization may receive financial remuneration from Valeant. I also understand that Valeant has the right to contact me directly by phone, mail, or email, if my email address was supplied on page 1, and to confirm product delivery and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation in the Valeant PAP at any time by either calling the Valeant PAP at **833-862-VPAP (833-862-8727)** or mailing a letter to **Valeant Patient Assistance Program, P.O. Box 429303, Cincinnati, OH 45242-9303.**

By signing below, I verify that the information I provide in this application, including all copies of documentation, if applicable, is complete and accurate, and that I am authorized to sign this application. I also verify that I am not currently receiving benefits or coverage for the product(s) selected on page 3 from Medicaid, Medicare, or any other public or private insurance or assistance program. I acknowledge and agree that I shall not report or count the value of any product provided to me under the Valeant PAP toward any insurance deductible or, if I am enrolled in Medicare Part D, as true out-of-pocket spending (TrOOP) under my Medicare Part D prescription drug benefit. In addition, I will not seek reimbursement from any insurance provider or plan, including any Medicare Part B or Medicare Part D plan, for the cost of any free product provided by the Valeant PAP and for the remainder of my eligibility period I will continue to receive all of my prescriptions for the selected products from the Valeant PAP. I also agree that I will contact Valeant if any of the information regarding my prescription drug coverage or insurance changes. I understand that this form expires in one year or when my program eligibility expires.

Patient or Authorized Representative Signature _____

Name (print) _____ Date _____

4 Alternate/Authorized Patient Representative (If Applicable)

Complete if Valeant PAP may address insurance or financial questions or other application-related issues with an Authorized Representative on your behalf.

Patient's Signature _____ **Date** _____

Authorized Patient Representative Name _____

Relationship to patient _____ Primary Phone # _____

Email _____

Patient Assistance Program Application

To be completed by the Prescriber

Patient Name _____

Does the patient have any known allergies (required)? None Known _____

Please list the names of other medications the patient is currently taking

None Medications _____

1 Product Information

Select from product listing below and attach original valid prescription(s) with physician signature

Eligible patients may be able to receive product through this program for up to one year, as long as a valid prescription remains on file. **This is not a prescription.**

SHIP TO (required) Patient's Home Prescribing Physician's Office

NOTE: Orders for Controlled Substances and products administered by the physician will be shipped to comply with all state rules and regulations pertaining to how these items can be transported.

Bausch + Lomb Products	
<input type="checkbox"/>	ALREX® (loteprednol etabonate ophthalmic suspension) 0.2%
<input type="checkbox"/>	BEPREVE® (bepotastine besilate ophthalmic solution) 1.5%
<input type="checkbox"/>	BESIVANCE® (besifloxacin ophthalmic suspension) 0.6%
<input type="checkbox"/>	LACRISERT® (hydroxypropyl cellulose ophthalmic insert)
<input type="checkbox"/>	LOTEMAX® (loteprednol etabonate ophthalmic gel) 0.5%
<input type="checkbox"/>	MACUGEN® (pegaptanib sodium injection) intravitreal injection
<input type="checkbox"/>	PROLENSA® (bromfenac ophthalmic solution) 0.07%
<input type="checkbox"/>	RETISERT® (fluocinolone acetonide intravitreal implant) 0.59 mg for intravitreal use
<input type="checkbox"/>	TIMOPTIC® in OCUDOSE® (timolol maleate ophthalmic solution) <input type="checkbox"/> 0.25% <input type="checkbox"/> 0.5%
<input type="checkbox"/>	VISUDYNE® (verteporfin for injection), for intravenous use
<input type="checkbox"/>	VYZULTA™ (latanoprostene bunod ophthalmic solution) 0.024%
<input type="checkbox"/>	ZIRGAN® (ganaciclovir ophthalmic gel) 0.15%
<input type="checkbox"/>	ZYLET® (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension)

Ortho Dermatologics Products	
<input type="checkbox"/>	ACANYA® (clindamycin phosphate and benzoyl peroxide) Gel, 1.2%/2.5%, for topical use
<input type="checkbox"/>	CARAC® (fluorouracil cream) Cream, 0.5%
<input type="checkbox"/>	CLINDAGEL® (clindamycin phosphate gel) topical gel, 1%
<input type="checkbox"/>	ELIDEL® (pimecrolimus) Cream, 1% for topical use
<input type="checkbox"/>	JUBLIA® (efinaconazole) topical solution, 10% <input type="checkbox"/> 4 mL <input type="checkbox"/> 8 mL
<input type="checkbox"/>	LOCOID® (hydrocortisone butyrate) Lotion, 0.1%, for topical use
<input type="checkbox"/>	LUZU® (luliconazole) Cream, 1% for topical use
<input type="checkbox"/>	NORITATE® (metronidazole cream) Cream, 1% for topical use only
<input type="checkbox"/>	ONEXTON® (clindamycin phosphate and benzoyl peroxide) Gel, 1.2%/3.75% for topical use
<input type="checkbox"/>	RENOVA® (tretinoin cream) 0.02% for topical use, pump
<input type="checkbox"/>	RETIN-A MICRO® (tretinoin) Gel microsphere for topical use <input type="checkbox"/> 0.06% <input type="checkbox"/> 0.08%
<input type="checkbox"/>	SOLODYN® (minocycline HCl) extended release tablets for oral use <input type="checkbox"/> 55 mg <input type="checkbox"/> 80 mg <input type="checkbox"/> 105 mg
<input type="checkbox"/>	ZYCLARA® (imiquimod) cream 3.75%, for topical use <input type="checkbox"/> 7.5 g pump <input type="checkbox"/> box of 28 packets

Salix Pharmaceuticals Products	
<input type="checkbox"/>	APRISO® (mesalamine) extended-release capsules
<input type="checkbox"/>	CYCLOSET® (bromocriptine mesylate tablets), for oral use
<input type="checkbox"/>	MOVIPREP® (polyethylene glycol 3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate, and ascorbic acid for oral solution)
<input type="checkbox"/>	RELISTOR® (methylnaltrexone bromide) tablets, for oral use, 90-count
<input type="checkbox"/>	RELISTOR® (methylnaltrexone bromide) injection, for subcutaneous use (7 single-dose pre-filled syringes per carton) <input type="checkbox"/> 8 mg/0.4 mL <input type="checkbox"/> 12 mg/0.6 mL
<input type="checkbox"/>	UCERIS® (budesonide) rectal foam
<input type="checkbox"/>	XIFAXAN® (rifaximin) Tablets, for oral use, 550 mg

Valeant Pharmaceuticals Products	
<input type="checkbox"/>	ANCOBON® (flucytosine) 500 mg Capsules
<input type="checkbox"/>	ANDROID® (C-III) (methylTESTOSTERone Capsules, USP), 10 mg
<input type="checkbox"/>	CUPRIMINE® (penicillamine) Capsules
<input type="checkbox"/>	DEMSE® (metyrosine) Capsules
<input type="checkbox"/>	LODOSYN® (carbidopa) tablets
<input type="checkbox"/>	MEPHYTON® (phytonadione) Vitamin K ₁ tablets
<input type="checkbox"/>	OXSORALEN-ULTRA® Capsules (methoxsalen capsules, USP, 10 mg)
<input type="checkbox"/>	SYPRINE® (trientine hydrochloride) capsules
<input type="checkbox"/>	TARGRETIN® (bexarotene) capsules, for oral use
<input type="checkbox"/>	TARGRETIN® (bexarotene) Gel 1%
<input type="checkbox"/>	TASMAR® (tolcapone) Tablets
<input type="checkbox"/>	ZELAPAR® (selegiline hydrochloride) Orally Disintegrating Tablets

<input type="checkbox"/>	Other _____ _____
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Before prescribing any product on the above list, please see full Prescribing Information, including any Boxed Warning, Medication Guide, and/or Patient Information, available at ValeantPAP.com or call Valeant Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.

Patient Assistance Program Application

To be completed by the Prescriber

Patient Name _____

2 Prescriber Information (*Required)

*First Name _____ *Last Name _____ *Designation _____

*Practice Name _____ Specialty _____

*Street Address _____

*City _____ *State _____ *ZIP Code _____

*NPI # _____ State License # _____ DEA # _____

Office Contact Name _____ Email _____

*Phone # _____ *Fax # _____

Business Hours (for deliveries) _____ AM PM to _____ AM PM

3 Shipping Information (Complete if shipping to prescriber's office and information is different from Prescriber Information)

Ship to Site/Facility Name _____ NPI # (if different from above) _____

Shipping Address _____

City _____ State _____ ZIP Code _____

Delivery Contact Name _____ Phone # _____

Business Hours (for deliveries) _____ AM PM to _____ AM PM

4 Prescriber Certification

I have determined, based on my independent clinical judgment, that the above-named patient should be treated with the Valeant product(s) identified on page 3. By signing below, I confirm that the patient is under my care on an outpatient basis; I will not charge the patient any fee for enrollment or other activities associated with the patient's participation in the Valeant PAP; I will not charge the patient for any professional services associated with the product(s) that are not covered by the patient's insurance provider or plan, or when the patient's costs associated with the prescribed product(s) represents a financial hardship and assistance has been approved by the Valeant PAP; I will not make any claim to any third party payer (e.g., Medicaid, Medicare, public or private insurance, etc.) for payment of product provided by the Valeant PAP; I will not sell, trade or return for credit the products(s) provided under the Valeant PAP; and I am not prohibited from participating in federally funded health care programs nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General. To the best of my knowledge, the patient does not have affordable third party insurance coverage for the selected product(s) through, for example, an HMO, private insurance, a State pharmacy program, Medicare, Medicaid, or Veterans Assistance, and the patient meets all other Valeant PAP eligibility requirements. By signing this form, I authorize Valeant PAP as my designated agent on behalf of the patient, to forward the prescription for the product(s) selected and presented herein by fax or other mode of delivery to the Valeant PAP dispensing pharmacy or distributor for fulfillment and/or dispensing. By including my email address on page 3, I agree to receive communication related to Valeant PAP by email.

Prescriber's Signature _____ Date _____

Physician's signature required. Stamped signatures are not allowed for controlled substances. **Special note:** New York prescribers must submit the patient's prescription on an original NY State prescription blank. For all other states, if not faxed, the prescription must be on a state-specific blank, if applicable for your state. **Faxed prescriptions must be faxed from the prescriber's office.**

Valeant Patient Assistance Program benefits, rules, and product availability are subject to change at any time without prior notification.

You are encouraged to report negative side effects of prescription drugs to FDA at www.fda.gov/Safety/MedWatch, or call 1-800-FDA-1088.

Please see full Prescribing Information, including any Boxed Warning, Medication Guide and/or Patient Information, available at ValeantPAP.com or call Valeant Medical Information at (877) 361-2719 to request that it be faxed, emailed, or mailed instead.

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