

CENESTIN<sup>®</sup> (Synthetic Conjugated Estrogens, A) TABLETS
PATIENT ASSISTANCE PROGRAM
QUALIFICATION FORM
1-800-425-3122

PhRMA

PATIENT'S INFORMATION

(Patient's First Name) (Patient's Last Name) (MI)

(Patient's Street Address)

(Patient's City) (State) (ZIP Code)

F

(Sex: M or F) (Date of Birth) (Patient's Phone)

(Patient's Social Security Number) Patient's Diagnosis (ICD.9 Code):

PATIENT'S INSURANCE AND RX DRUG COVERAGE

(CHECK ALL THAT APPLY):

Patient's insurance coverage and prescription drug coverage (partial or full):

- Medicare Medicaid Medicaid QMB Uninsured

Check all that apply: Does patient have prescription Rx coverage?

- Medicare Managed Care State/Local government program Federal program Private insurance / HMOs Private foundation Other prescription drug program. Specify:

If Rx Coverage is Yes, is Cenestin covered? Yes No

If Rx coverage, name of insurance carrier:

PATIENT'S INCOME (CHECK ONE:)

For Patient's who are Single or without dependents: Does patient earn more than \$15,000 per year? Yes No

For Patient's who are Married or with dependents: Does patient earn more than \$25,000 per year? Yes No

PATIENT/APPLICANT DECLARATION

I understand that completing this form does not ensure that I will qualify for this program. I verify that the information provided in this qualification form is complete and accurate. I agree to notify the Cenestin Patient Assistance Program if I obtain prescription drug coverage or if I no longer meet the income criteria.

I understand that the program administrators reserve the right any time and without notice to modify the application form, modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time.

Patient Signature

Date

PRESCRIBER'S INFORMATION

(Prescriber's First Name) (Prescriber's Last Name) (MI)

(Prescriber's Street Address 1)

(Prescriber's Street Address 2)

(Prescriber's Street Address 3)

(Prescriber's City) (State) (ZIP Code)

(Prescriber's Phone) (Prescriber's Fax)

(Prescriber's Specialty) (Prescriber's State License #)

(Prescriber's e-mail address) When you provide your e-mail address, you agree that Duramed Pharmaceuticals, Inc. and its agents may contact you in the future about health-related materials or programs.

CENESTIN DOSAGE

This section of the form will serve as the Cenestin prescription.

Quantity: 1 bottle of 100 tablets

Check dosage:

Cenestin 0.3 mg tablets Cenestin 0.45 mg tablets

Cenestin 0.625 mg tablets Cenestin 0.9 mg tablets

Cenestin 1.25 mg tablets

QD sig - one tablet daily QHS sig - one tablet every bedtime

Other:

PRESCRIBER ATTESTATION

I hereby request Cenestin for the above named patient.

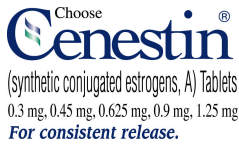
To the best of my knowledge this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I certify that this prescription is medically indicated for this patient and that I will be supervising the patient's treatment. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

I have received a signed Patient Authorization to Disclose Protected Health Information from the above named patient.

Prescriber's Original Signature:

Date:

FAX FORM TO: 1-800-685-2577
OR MAIL TO:
CENESTIN PATIENT ASSISTANCE PROGRAM
1878 Arena Drive, Hamilton NJ 08610



**CENESTIN<sup>®</sup> (Synthetic Conjugated Estrogens, A) TABLETS**  
**PATIENT ASSISTANCE PROGRAM**  
**1 – 800 – 425 – 3122 – PHONE**  
**1 – 800 – 685 – 2577 – FAX**

**Patient Authorization to Disclose Protected Health Information**

**To the Patient:** I understand that during the course of my participation in the Cenestin<sup>®</sup> Patient Assistance Program, that personal identifying information provided will be provided to Duramed Pharmaceuticals, Inc. its affiliated companies and subcontractors on a need to know basis for purposes of administering the program. I understand this information constitutes Protected Health Information (PHI) under the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA).

**Authorization Statement**

I, (Patient's Name) \_\_\_\_\_, authorize my prescribing physician,  
(Prescriber's Name) \_\_\_\_\_  
(Prescriber's Address) \_\_\_\_\_

caregiver and other sources, as deemed necessary to disclose such PHI provided to Duramed Pharmaceuticals, Inc., its affiliated companies and subcontractors on a need to know basis for purposes of administering the program for the duration of my participation in the program.

I understand that Duramed Pharmaceuticals, Inc., its affiliated companies and subcontractors will protect the information received in accordance with HIPAA and the other relevant State and Federal privacy laws. I further understand that this authorization permits Duramed Pharmaceuticals, Inc., its affiliates and subcontractors to share my PHI with individuals or entities who are not bound by the privacy requirements of HIPAA and that once in their possession, my PHI could be used or re-disclosed in a way no longer protected by HIPAA.

I understand that I may revoke this authorization, in writing, at any time by addressing such revocation to my prescribing physician and/or caregiver and that only a written revocation addressed to such person will constitute an effective withdrawal of my authorization.

**Required Signature**

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

If signed by patient's legal representative, complete the following:

Print name of legal representative: \_\_\_\_\_

Describe representative's authority to act for patient: \_\_\_\_\_

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**Important:**

**To the Patient:**

Once you have completed and signed this authorization form, please give it to your prescriber. Do not send it to the Cenestin<sup>®</sup> Patient Assistance Program.

**To the Prescriber:**

Retain the original copy of the Patient Authorization to Disclose Protected Health Information for your records. Please return a copy of this signed form along with the completed Qualification application form to the Cenestin<sup>®</sup> Patient Assistance Program, 1878 Arena Drive, Hamilton, NJ 08610, or fax to 1-800-685-2577.