ACIPHEX® (rabeprazole sodium) PATIENT ASSISTANCE PROGRAM

The following information is required to enable the Patient Assistance Program specialists to determine eligibility for a patient. Please complete this form, attach tax return and return by mail or fax.

Mail: Aciphex® Patient Assistance Program
PO Box 220458
Charlotte, NC 28222-0458

Telephone: (800) 523-5870 Fax: (800) 526-6651

New Application ☐ Re-application ☐

PATIENT INFORMATION (Please Print Clearly)

Patient Name: _____

Name of Guardian (if appropriate): _____

Street Address: _____

City, State Zip: _____

Telephone: Day (____)____-_____ Evening (____) ____-_____

SS#: _____/_____/_____ M _____ F _____

HEALTH INSURANCE INFORMATION

Primary Insurance

Health Insurance Company: _____

Telephone: (_____)_____

Policy ID Number: _____ Group ID Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber's Relation to Patient: _____

Are you covered by secondary insurance, including Medicaid or Medicare?
☐ YES ☐ NO
(If yes, please provide name, telephone number, and policy number.)

_____

_____

Do these policies cover prescription drugs? ☐ YES ☐ NO

Public Programs

Have you applied to any of the following for health coverage?
Medicaid: ☐ YES ☐ NO
Result: _____
Supplemental Security Income (SSI): ☐ YES ☐ NO
Result: _____
Social Security Disability (SSDI): ☐ YES ☐ NO
Result: _____

FINANCIAL INFORMATION

Gross Annual Household Income and Source of Income:

Salary/Wages/Unemployment	$_____
Pension/Social Security	$_____
SSI	$_____
SSDI	$_____
Other: _____	$_____
Total	$_____

Number of household members dependent on income stated above (include applicant) _____

PLEASE CHECK APPLICABLE BOX

Attached is a copy of my most recent federal tax return*	
I do not file federal taxes	

***Required on initial applications and annually thereafter.**

APPLICANT DECLARATION

"I promise that the information on this form is correct and complete. If needed, Eisai Inc. and Janssen Pharmaceutica Inc. and its Aciphex® Patient Assistance Program (the "program") may request and obtain information about my, or my family's income to enroll me in the program. 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."

Please indicate your agreement with these terms by signing below.

Patient Signature_____ Date_____

PHYSICIAN INFORMATION

Physician Name: _____

Facility Name: _____

Street Address: _____

City, State Zip: _____

Tel: (_____)_____ Fax: (_____)_____

Business Hours: _____Office Contact Name: _____

PRODUCT DISTRIBUTION INFORMATION

Indicate shipping address if different from above address. (Please provide facility name, address, telephone, and contact person).

_____

_____

PRESCRIPTION INFORMATION

Patient Name_____

Aciphex® (rabeprazole sodium)

Dosage **20 mg. Tablets** Sig._____

Quantity **monthly (1 bottle = 30 tablets)**

Number of Refills_____

State License # _____

Date_____

To the best of my knowledge, this patient does not have prescription drug insurance coverage (including Medicaid, county funded or other public programs) for Aciphex®.

Eisai Inc. and Janssen Pharmaceutica Inc. request that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product or administration of product provided under the program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature _____

Aciphex®
(rabeprazole sodium)
Patient Assistance Program

Authorization to Share Health Information for Reimbursement or Patient Assistance Programs

Provider Instructions: Patients must complete this form before they can participate in the Program.

I, _____, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for ACIPHEX® (rabeprazole sodium) to Lash Group. Lash Group runs the ACIPHEX® Patient Assistance Program (the "Program") for Eisai Inc. and Janssen Pharmaceutica Inc. ACIPHEX® is manufactured by Eisai Inc. and marketed by Janssen Pharmaceutica Inc.

This information can include spoken or written facts about my health and payment benefits. It can include copies of records from my health care providers or health plans about my health or health care.

Lash Group and Janssen will use and give out this information to see if I qualify for the Program and to run the Program. People who work for and with Lash Group, Eisai Inc., and Janssen Pharmaceutica Inc. may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information Lash Group or Eisai Inc. and Janssen Pharmaceutica Inc., but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group, Eisai Inc., and Janssen Pharmaceutica Inc.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Sign Here: _____ Date: _____

Patient Name: _____

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: _____

By: _____
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

A copy of this form must be provided to the patient.