

TAP's Prevacid Patient Assistance Program (PAP) recently had some changes made to the requirements for patient enrollment.

Effective 01 June 2006,

All patients will be required to furnish proof of income when enrolling. They will still be required to meet the household income of below 200% of Federal Poverty Level (FPL) and not be covered under any prescription drug coverage (other than Medicare Part D). The types of proof of income are provided on the application form, but the most common will be Federal Tax Return Form 1040.

Medicare Eligible Patients will be allowed to enroll in the program provided they meet the following requirements. Most requirements are outlined on application form.

- If they have enrolled in a Prescription Drug Plan (PDP), they must furnish us their plan name and address. We will notify the drug plan the patient is receiving Prevacid through our Patient Assistance Program (PAP).
- If they elect not to sign up for a PDP, they will be allowed to enroll in our PAP.
- Medicare Eligible Patients will only be allowed to sign up for a Calendar year. For example, if they sign up in July 2006, their current enrollment will terminate on December 31st and they will have to re-enroll for 2007. They will have full enrollment for the entire calendar year of 2007.
- Their household income is between 135% and 200% of FPL. Income below 135% will be denied because they qualify for Low Income Subsidy (LIS) under Medicare. This can be appealed and approved with a LIS denial letter from Medicare.



TAP PHARMACEUTICALS INC.

PREVACID PATIENT ASSISTANCE PROGRAM

PO Box 66586

St. Louis, MO 63166-6586

Instructions

The TAP Prevacid Patient Assistance Program (the "TAP Program") provides Prevacid at no charge to patients in need. The need of a patient is determined according to guidelines established by TAP that are based on federal standards. The TAP Patient Assistance Program may be changed or discontinued at any time in the sole discretion of TAP.

Enrollment Process: Call 1-800-830-1015 to obtain an application for the TAP Program. An application will be promptly faxed to the physician's office.

Please complete all applicable sections. If an item does not apply, please mark N/A on the line. Incomplete applications will not be processed.

To assess a patient's need, **financial documentation is required**. Applications submitted without the proper financial documentation will not be processed and will be returned to the physician with a letter specifying the information that is missing. Acceptable documentation means the patient's most recent federal income tax return or, if the patient did not file a federal income tax return in the last sixteen (16) months, then please submit each of the following that applies to the patient:

- Yearly benefits statement (SSA1099, 4506 or 4506T)
- IRS Telefile Worksheet
- W2 Tax statement
- Social Security, Pension, or Railroad Retirement statements (SSA-1099, 4506T)
- Statements of interest, dividends or other income (1099-INT, 1099, 1099T, 1099-DIV)
- Section 6 of the application can be completed in place of submitted the 4506 or 4506T

Submission of Application, Approval, and Shipment of Medication: Once the enrollment application is complete, please fax it to 1-800-394-2794. A TAP Program specialist will evaluate the application using the pre-established program guidelines to determine the patient's eligibility. If the patient is approved for participation in the program, an approval letter will be mailed to the patient and physician confirming the patient's acceptance into the program and a 90 to 100-day supply of Prevacid will be shipped to the physician's office within 4-5 business days. If an application is denied, a denial letter will be mailed to the patient and to the physician.

Continued Assistance/Refill Process: If the patient needs assistance beyond the initial supply provided, re-orders must be placed by physicians by calling 1-800-830-1015.

Period of Support and Reapplication Process: The period of support and the reapplication requirements under the TAP Program for Medicare Part D enrollees and those who are not enrolled in that program may be different.

Patients Not Enrolled in Part D:

A patient who is not enrolled in Part D may receive medication for up to one year. To receive support under the TAP Program beyond one year, the patient must reapply on an annual basis. Eligibility will be determined based on the updated information provided at the time of reapplication.

We strongly encourage the submission of reapplications sufficiently in advance of the end of an existing period of support so that no interruption in treatment occurs because of the need to submit a completed application and to have that application evaluated.

Patients Enrolled in Part D:

A patient enrolled in Medicare Part D may receive medication for the remainder of the calendar year in which that patient was approved to participate in the TAP Program. Part D enrollees may not receive medication beyond the end of that calendar year without reapplying and being approved for the subsequent calendar year. The patient may re-apply for the next calendar year by following the same enrollment process described above. Eligibility will be determined based on the updated information provided.

We strongly encourage the submission of reapplications sufficiently in advance of the end of an existing calendar year so that no interruption in treatment occurs because of the need to submit a completed application and to have that application evaluated.

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Enrollment Status:

- New Enrollment
 Re-Enrollment
 Re-Order (please complete sections 1 and 2 only)

SECTION 1 PHYSICIAN INFORMATION

Physician Name		DEA/State License #
Address		City, State & Zip Code
Office Ph. Number ()	Office Fax Number ()	Office Contact person
Patient Diagnosis:		
Dosage requested, check one below:		
Prevacid Dosage <input type="checkbox"/> 30 mg 100 ct (1 bottle-100 day supply) <input type="checkbox"/> 15 mg 30 ct (3 bottles-90 day supply)		Prevacid SoluTab Dosage <input type="checkbox"/> 30mg 30 tabs (3 boxes-90 day supply) <input type="checkbox"/> 15mg 30 tabs (3 boxes-90 day supply)
I certify that I will dispense the medication only for the use by the patient designated below. Neither the patient nor any third party payer, (including Medicare and Medicaid) was or will be charged for this product. Additionally, I understand this medication cannot be sold or offered for sale or trade.		
Physician's signature (Required)		Date
X		

SECTION 2 PATIENT INFORMATION

Name	SSN/ID Number	Date of Birth
Address		City, State & Zip Code
Daytime Phone () -	Legal US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of people in household (including self): (Circle One) 1 2 3 4 5 6 7 8

SECTION 3 PATIENT INSURANCE INFORMATION

Do you have Prescription Drug Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial Coverage	Are you enrolled in Medicare Part D? <input type="checkbox"/> Yes* <input type="checkbox"/> No* *If yes, see section 7, If no, see section 8	Are you enrolled in Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
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SECTION 4 HOUSEHOLD FINANCIAL INFORMATION

You must list all sources of Total Monthly Household Income and attach a copy of your most recent U.S. income tax return (i.e., IRS Form 1040, 1040 A, 1040EZ, 1099). If you do not file a federal income tax return, please see section 6. Total Monthly Household Income includes gross monthly income of patient, spouse and others living in household. You must include salary, pension, Social Security income, SSI-Supplemental Security income, Social Security Disability and Unemployment Compensation.

Salary/Wages \$ _____	Social Security \$ _____	Child Support/Alimony \$ _____
Disability \$ _____	Pension/Retirement \$ _____	Unemployment/Work Comp \$ _____

Gross Monthly Income Total: \$ _____

SECTION 5 PATIENT SIGNATURE

USE AND RELEASE INFORMATION FOR PATIENT ASSISTANCE PROGRAM ("PROGRAM")

I allow my doctor listed here and my health plans, if any, to use, share, and release my information requested by the Program. This information includes my name, information from my medical record, health plan information and financial information. My information will be given to TAP Pharmaceuticals Inc. ("TAP"), AmeriCares and any other contractors or partners that help with the Program. These uses and releases of my information are so that I may apply and, if approved, receive **Prevacid** from the TAP Program. My information will be treated confidentially to the extent required by law. Federal law may allow someone who gets my information based on this form to use or release it in some way not discussed here. This permission ends one year after my application is accepted or denied. I can choose not to sign this form or cancel this permission anytime. If I want to cancel this permission to my doctor or health plans, I will write to my doctor or health plans. My cancellation will not apply to information already obtained by health care providers and health plans if they have already used or released my information, or acted in reliance on my permission. Not signing this form will not affect my health care treatment outside the TAP Program, health plans' payment for health care, or my ability to get benefits from health plans. Signing this form is not a guarantee that I will be able to receive **Prevacid** from the TAP Program.

My signature certifies that the information on this form is true and correct. I certify that (i) I do not have prescription drug coverage, with the possible exception of Medicare Part D coverage; (ii) I will notify the TAP Program immediately in writing if I obtain prescription drug coverage; and (iii) I will not submit to any third-party payer a claim for any medication that may be provided to me by the TAP Program. If I enroll in Medicare Part D, I certify that I will comply with all requirements listed in Section 7 of this application. I consent to the release by my health care providers of my medical information pertaining to the TAP Program, health plans' payment for health care, or my ability to get benefits from health plans. I authorize TAP and its agents and assignees to use the information on this application to process the request for medication from the TAP Program and further authorize the use of my Social Security number for identification purposes and record keeping. I understand TAP reserves the right at any time without notice to modify or discontinue this program and its eligibility criteria.

Patient or family member's signature (Required)	Date
X	

TAP Pharmaceuticals

Prevacid® Patient Assistance Drug Program

1-800-830-1015 Phone
1-800-394-2794 Fax

Section 6 Request for IRS verification that you did not file a tax return

If you did not file a Federal tax return, sign below in this section to acknowledge and agree that:	
<ul style="list-style-type: none"> You are asking the IRS to send confirmation to TAP that you did not file a Federal tax return. The IRS does not control how TAP uses this information. The IRS may call you to make sure you want to share this confirmation. 	IRS: send verification to: TAP PHARMACEUTICALS INC. PREVACID PATIENT ASSISTANCE PROGRAM PO Box 66586 St. Louis, MO 63166-6586
Patient signature for IRS request	Date

Section 7 Medicare Part D Prescription Drug Plan Contact Information

This section must be completed by any applicant who has enrolled in a Medicare Part D Prescription Drug Plan.		
<ol style="list-style-type: none"> 1. I understand that if approved for assistance I will be able to receive the requested medication from the TAP Patient Assistance Program (the "TAP Program") for the remainder of the enrollment calendar year for which my application was approved. 2. I agree that I will not seek the requested medication from my Medicare Part D plan for the remainder of the enrollment calendar year. 3. I agree that I will not seek or accept reimbursement from my Part D plan for any medication received from the TAP Program. 4. I agree that I will not seek true out-of-pocket (TrOOP) credit for any medication received from the TAP Program because I understand that medication received from the TAP Program will not count toward my TrOOP. 5. I give consent for the TAP Program to disclose my enrollment in the TAP Program to my Medicare Part D plan. 6. I agree to notify the TAP Program immediately in writing if my prescription drug coverage changes in any way. 7. I understand that any assistance provided through the TAP Program is temporary and that the TAP Program can be changed or discontinued at any time in the sole discretion of TAP. 		
Enrollment Calendar Year means the calendar year for which this application is being submitted. Re-enrollment applications for the next calendar year will not be accepted prior to October of the current year.		
TAP Program enrollment is being requested for the following calendar year:		
Prescription Drug Plan Name:		
Prescription Drug Plan Phone Number:		
Prescription Drug Plan Address:		
City:	State:	Zip:
Patient Signature		Date

Section 8 Affirmation of Non-Enrollment in Medicare Part D Plan

This section must be completed by any applicant or re-enrollee who is eligible for Medicare Part D but is not currently enrolled in a Medicare Part D plan.	
<ol style="list-style-type: none"> 1. I declare and affirm that I am not currently enrolled in a Medicare Part D plan. 2. I agree to notify the TAP Program in writing immediately if my prescription drug coverage changes in any way or if I enroll in a Medicare Part D plan. 3. I understand that any assistance provided through the TAP Program is temporary and that the TAP Program can be changed or discontinued at any time in the sole discretion of TAP. 	
Patient Signature	Date