



# Patient Assistance Program

PO Box 4008  
Clinton, NJ 08809  
(800) 511-2120



## STEP ONE – Patient Qualification

- Number of dependants including the patient? \$ \_\_\_\_\_
- What is the patient's annual income? \$ \_\_\_\_\_
- Annual physician expenses \$ \_\_\_\_\_
- Annual prescription expenses \$ \_\_\_\_\_
- All other medical expenses \$ \_\_\_\_\_
- Total medical expenses \$ \_\_\_\_\_
- Total income less expenses \$ \_\_\_\_\_

## STEP TWO – Patient Information

Patient First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Sex: M F Marital Status: S M D W

Is the patient a US Citizen: YES NO Patient Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is the patient a Veteran: YES NO Does the Patient have ANY Medical or Prescription Coverage? \_\_\_\_\_ If so, please indicate the Insurance Company, Policy Holder and Number, and contact #. \_\_\_\_\_

I attest that the information included in this application is correct and complete. I understand that the information on this enrollment form and my prescription drug will only be used for purposes of determining eligibility in and administering the Xcel Patient Assistance Program. I further understand that documentation may be requested to verify financial or insurance information. I understand that assistance in the form of free drug is contingent upon my ability to meet program eligibility criteria, and Xcel Pharmaceuticals reserves the right, at any time and without notice, to modify or discontinue this program and its eligibility criteria. I authorize the Xcel Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application and to provide services through this program.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STEP THREE – Product Information

Product Requested: (circle product and strength)

|                  |                                   |      |         |                  |         |       |
|------------------|-----------------------------------|------|---------|------------------|---------|-------|
| <b>Diastat</b>   | 2.5mg                             | 10mg | 20mg    | <b>Mysoline</b>  | 50mg    | 250mg |
| <b>Migranal</b>  | 4mg                               |      |         | <b>D.H.E. 45</b> | 1mg     |       |
| Times/day: _____ | Duration of therapy (circle one): |      | 30 days | 60 Days          | 90 Days |       |

## STEP FOUR – Physician Information

Physician First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX Number: \_\_\_\_\_ Email: \_\_\_\_\_

Specialty: \_\_\_\_\_ State License Number: \_\_\_\_\_ DEA Number: \_\_\_\_\_

Patient Last seen on: (MM/DD/YYYY): \_\_\_\_\_ Office Contact Name \_\_\_\_\_

Do you verify that the information provided is complete and accurate to the best of your knowledge? \_\_\_\_\_ YES NO

Do you agree to have medication sent to the physician's office for dispensing? \_\_\_\_\_ YES NO

I certify that product requested is medically indicated for this patient, and I will be supervising the patient's treatments.

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

(Original signature – Stamps not accepted)

**Please submit a prescription with this form and FAX to 908-713-7710**

You will be notified of our decision within 48 hours. The Xcel Patient Assistance Program will follow up with each applicant within four weeks of his or her initial product shipment. Please note that you can complete the entire process online at rxhope.com