



ENROLLMENT APPLICATION
All fields required
Mail completed application to:
Validus Pharmaceuticals, Inc.
c/o Saddle River Marketing Concepts
600 Valley Health Plaza
Paramus, NJ 07652

Initial Enrollment Instructions

- Patient Information & Eligibility Section must be complete with original signature.
- Practitioner Section must be complete with original signature.
- Please attach an original prescription, written for a three-month supply of medication to the application.
- Attach copy of most recent federal tax return for patient. If the patient does not file, please attach other proof of income (W-2/1099, social security, pension or disability statement, etc.).
- Updated proof of income is required annually.
- Mail original application, original prescription and proof of income to the address listing above.
- Both the patient and practitioner will be advised in writing of any denied requests.
- All incomplete applications will be returned to either the patient or practitioner for completion.

Continuing Enrollment Instructions

- Patient Information & Eligibility Section must be complete with original signature.
- Practitioner Section must be complete with original signature.
- Please attach an original prescription, written for a three-month supply of medication to the application.
- Mail original application and original prescription to the address listed above.
- Both the patient and practitioner will be advised in writing of any denied requests.
- All incomplete applications will be returned to either the patient or practitioner for completion.

Program Eligibility

- Patient must be a legal resident of the United States.
- Patient cannot be directly or indirectly (through other household members) covered or eligible for any government prescription coverage such as Medicaid, Veteran's Administration, or any state or local programs.
- Patient cannot be enrolled in Medicare Part D.
- Patient cannot be directly or indirectly (through other household members) covered by any private prescription coverage such as an HMO or PPO plan.
- Patients must meet specific program criteria and not everyone who enrolls will qualify for coverage.



• 2001 Route 46 East, Suite 310 • Parsippany, NJ 07054 •



Patient Assistance Program - Enrollment Form

IF ALL INFORMATION IS NOT CLEAR AND COMPLETE, THIS FORM WILL BE RETURNED.

Section 1: Patient Information

Patient's Name: _____ SS# _____
(First) (Last) (M.I.)

Address: _____ Date of Birth _____
 _____ Phone # _____

City: _____ State: _____ Zip: _____ Marital Status _____

Eligibility

- A. Is the patient a legal U.S. resident? Yes No
- B. Is the patient directly or indirectly (through other household members) covered or eligible for prescription coverage in any government program (i.e. Medicaid, VA or any other state or local program)? Yes No
- C. Is the patient enrolled in Medicare Part D? Yes No
- D. Is the patient directly or indirectly (through other household members) covered or eligible for prescription coverage with any private programs (i.e. private insurance, HMO plan, PPO plan)? Yes No
- E. Total ANNUAL household income; including social security and pension benefits..... \$ _____
- F. Number of persons residing in household (including patient)..... _____

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of public or private reimbursement or coverage of drug costs. I also certify that I am unable to afford the cost of the medication. I understand that Validus Pharmaceuticals, Inc. reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria, or to refuse to distribute any drugs under this program to any patient. I understand that I am expected to seek any available state or government assistance before reapplying to the Validus Pharmaceuticals Patient Assistance program. I authorize Validus Pharmaceuticals, Inc. or its agent to obtain insurance coverage information from my insurance company and any other information necessary including my personal medical information to complete the application process, assess eligibility or verify accuracy of any information provided in this application. I authorize Validus Pharmaceuticals, Inc. to use this form to administer the Patient Assistance Program. I agree not to submit an insurance claim or any other claim for payment to any third party payor (private or government) for the prescription product. I agree not to resell, offer for sale, trade or barter, or return for credit the prescription product and that it will be utilized solely for my personal use.

 Patient Signature (must be original - no photocopies) Date

Section 2: Practitioner Information

Name: _____ Phone # _____
(First) (Last) (M.I.)

Address: _____ Fax # _____

City: _____ State: _____ Zip: _____ DEA # _____
(If no DEA# is available, please attach a copy of state license.)

Contact Name: _____

I represent that the information contained in this application is complete and accurate to the best of my knowledge. I certify that the use of the indicated medication is medically necessary and I will be evaluating the patient's treatment. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the prescription product or for professional services rendered in association with the prescription of the product. I understand that Validus Pharmaceuticals, Inc. reserves the right to modify or terminate this program at any time or to refuse to distribute the medication under this program to any patient or physician. Validus Pharmaceuticals, Inc. also reserves the right to modify the financial eligibility criteria at any time. My signature certifies that goods received from Validus Pharmaceuticals, Inc. are for the use of the above named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. Validus Pharmaceuticals, Inc. reserves the right to recall the product when necessary.

 Signature of Licensed Practitioner (Must be original - No stamped signatures or photocopies) Date

All information in this application will be kept confidential to the extent permitted by law and regulation.