



## PATIENT SAVINGS PROGRAM

To apply for the Tibotec Therapeutics Patient Savings Program complete and sign this application. Please mail or fax the application to: PO Box 22042, Charlotte, NC, 28222-0242 or (866) 961-7170

### PATIENT INFORMATION

Name: \_\_\_\_\_ Primary Telephone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address, City, State, ZIP \_\_\_\_\_

### FINANCIAL INFORMATION (All Values Should Reflect Yearly Amounts for Entire Household)

Total Gross Yearly Income \$ \_\_\_\_\_ Please provide name of your insurance carrier for prescription coverage \_\_\_\_\_  
Household Size: \_\_\_\_\_ Estimated co-pay or out of pocket expense for covered Tibotec Therapeutics Products \_\_\_\_\_  
(Number of people who contribute to or are dependent on your household income) \_\_\_\_\_

### PATIENT DECLARATION

"I promise that the information on this form is correct and complete. If needed, the Tibotec Therapeutic Patient Savings Program (the "Program") may request and obtain information from me about my or my family's income to enroll me in the Program. People who work for the program administrator may see my information but they may use it only to help me get assistance with the cost of my drugs and to run the program. Every effort will be made to keep my information private but if it is accidentally given out, federal privacy laws will not protect it. I can withdraw this consent at any time but it will not change any actions taken before I withdrew consent. I understand that the Program administrators reserve the right at 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. I understand that the Program is not health insurance and will only provide out of pocket cost assistance for eligible Tibotec Therapeutics products. I will notify the Program within 30 days if there is any change in the status of my eligibility (related to changes in my income or health coverage) to receive assistance through this program. This includes a change in my eligibility to participate in the Medicare Program due to change in my age or disability status or my enrollment in Medicare Part D."

Please indicate your agreement with these terms by signing below.

Patient Signature :

Date :