Patient Assistance Program (PAP) Application

Alcon Cares, Inc. (ACI) is a foundation committed to supporting access to Alcon medications and serving as an integral link between the healthcare provider and our local communities to help preserve and restore sight to the underserved. If you are experiencing financial hardship and have limited or no prescription coverage, you may be eligible to receive Alcon medication free of charge.

INSTRUCTIONS

1. **Patient / Legal Guardian complete Section 1: Patient Information**
   - Additional Required Items: Copy of most recent Federal Income Tax Return. If you do not file taxes, then provide current copies of household YTD statements or current proof of household income from all persons in the household
   - Do not send original documents with your application
2. **Healthcare Provider (HCP) complete Section 2: HCP Information and Product Request**
   - For over-the-counter (OTC) medication, if required by your state (i.e. NY or DE), please include a blank original script
3. **Submit Complete Application**
   - Mail to address below or fax to 800.554.2660
   - Allow 3 weeks for processing
   - Retain a copy of the completed application to request refills; refill requests cannot be placed over the phone.

CONTACT INFORMATION

Fax: 800.554.2660

Mail: Alcon Cares, Inc. TA-4-13
6201 South Freeway
Fort Worth, TX 76134-0450

QUESTIONS

Phone: 800.222.8103

Email: Patient.Assistance@Alcon.com

Section 1: Patient Information

To be completed by patient or legal guardian

Last Name: **First Name:**

Street Address:

City, State, Zip Code:

Phone Number: **Email:**

Date of Birth: **US Resident:** ☐ **Yes** ☐ **No** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed**

HEALTH INSURANCE INFORMATION

Do you have private (Commercial) insurance? ☐ **Yes** ☐ **No** **Does this include a prescription drug benefit?** ☐ **Yes** ☐ **No**

Do you have Medicare? ☐ **Yes** ☐ **No** **If YES, check all that apply:** ☐ **PART B** ☐ **PART D** ☐ **PART C** (Medicare Advantage plan)

Do you have coverage through a state Medicaid Program? ☐ **Yes** ☐ **No**

Section 1: Patient Information (continued)

FINANCIAL INFORMATION

How many people are dependent upon the household income, including the persons who have income?

Total Annual Household Income earned by persons living in the household (gross): $

☐ **Please check this box if you did not file a tax return**

Please provide supporting income documents:

- *Copy of most recent Federal Income Tax Return or other proof income, if any, such as W2, Social Security statement (1099), or 3 months of paycheck stubs. If you do not file taxes, then provide current copies of household year-to-date statements or current proof of household income from all persons in the household.*
- *Do not send original documents with your application*

Patient Authorization: I certify that I have provided my prescribing physician with all of the necessary consents authorizing him/her to release my health information to ACI. I also may revoke (withdraw) this authorization with respect to PAP at any time in the future by calling 1-800-222-8103 or writing to Alcon Cares, Inc. TA 4-13, 6201 South Freeway, Fort Worth, TX 76134-0450. My refusal or future revocation will not affect the commencement or continuation of my treatment by my health care providers (HCPs); however, if I revoke this authorization, I may no longer be able to participate in programs administered by ACI. If I revoke this authorization, ACI will stop using or sharing my information (except as necessary to end my participation in PAP) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. Unless revoked, this authorization will remain in effect for one year.

Declaration Regarding Privacy: I give permission for my HCPs, pharmacies, service providers and their contractors ("Health Care Providers"), health insurer(s) and their contractors ("Insurers"), to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to ACI, so that ACI can administer the PAP by: (i) providing me with access to the product which I am prescribed, (ii) providing me with information about Alcon products, (iii) providing me with medication reminders, and (iv) conducting quality assurance, surveys, and/or other internal business activities in connection with the PAP program. I give permission to ACI to disclose my Personal Information to my Health Care Providers, Insurer(s), caregivers, Alcon Vision, LLC, its affiliates, and service providers ("the Companies"), for the purposes described above. I also give permission to ACI to combine or aggregate any information collected from me for the purpose of providing or administering program services. I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law and applicable state law. I agree to be contacted by ACI by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the PAP application for all purposes described in this Patient Authorization. I also agree to be contacted by ACI and others on its behalf by telephone calls and text messages made by or using an autodialer or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys, and confirming that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided. I agree to notify ACI promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that the Companies do not permit my Personal Information to be used by their business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Declaration Regarding Incurred Drug Expenses: I agree that I will seek no reimbursement for any medication obtained under this program.

Applicant Declaration Regarding Accuracy and Completeness of Information: I promise the information on this form is correct and complete. If needed, ACI may request and obtain additional information about me or my family's income to enroll me in the program.

Patient Acknowledgment: I acknowledge that my participation in the program is subject to ACI's approval and ACI expressly reserves the right to refuse my participation. I indicate my agreement with these terms by signing below.

Patient or Legal Guardian Signature: _____ **Date:**

Patient or Legal Guardian Printed Name:

Section 2: Healthcare Provider Information and Product Request

HEALTHCARE PROVIDER INFORMATION

HCP Last Name: **HCP First Name:**

DEA / State License Number: **State:**

Facility Name:

Street Address:

City, State, Zip Code:

Phone Number: **Fax:** **Business Hours:**

MEDICATION(S) REQUEST

Please print clearly.

NOTE: This application will serve as the prescription. If required by your state (ie. NY or DE), please fax a blank original script.

☐ **New (First six-month supply request)**

☐ **Refill (Second six-month supply request)** **Date:**

MEDICATION(S)	STRENGTH	DOSAGE	DURATION

I understand that all medication(s) shipped to my facility address for this patient are my responsibility to distribute to the patient. Prescription medications can only be shipped to the HCP's facility. OTC products may be shipped to the patient's home.

Do the OTC product(s) need to ship to the patient's address? ☐ **Yes** ☐ **No**

I certify that I am the physician who has prescribed the medication identified above to the previously identified patient. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I understand that participation in this program is neither connected to the marketing of Alcon products, nor requires the purchase of Alcon products. I acknowledge that PAP is exclusively for purposes of patient care and not for remuneration of any sort. I understand that ACI may revise, change, or terminate programs at any time. My signature below confirms that I agree to these terms as further articulated in the attached program description and that there is a valid medical need for this patient's prescription. I certify that the above therapy is medically necessary and that this information is accurate to the best of my knowledge.

Healthcare Provider's Signature: _____ **Date:**

For Nurse Practitioners and Physician Assistants, please provide the name and license number of the doctor you are prescribing under.

Physician's Name: **State License Number:**

Patient Assistance Program (PAP) Application

AlconCares™

Alcon Cares, Inc. (ACI) is a foundation that offers a patient assistance program to qualified individuals at no charge. The ACI patient assistance program is open to any patient who cannot afford an eye-care medication prescribed by their US-licensed healthcare provider. Eligibility is based on several factors, including income limits that are tied to US Government Census Bureau figures, available through public sources such as the internet or library, and the patient's type of insurance coverage. Patients typically meet the income test at 350% (three-and-a-half times) the current year's poverty level designated by HHS for the number of persons living in a household. Current HHS guidelines can be found at http://aspe.hhs.gov/poverty/.

Each request is subject to ACI's approval. We would like to accommodate all requests, but we cannot due to limited resources. Our criteria and limits are designed to help us provide medication to patients who are most in need. ACI reserves the right to modify or discontinue this program at any time. The products provided under this program are not to be sold, traded, or used for any other purpose.

- An approved application is good for one year from the date of last signature. If an application is denied, ACI will send a letter to the patient stating the reasons for denial and the action necessary to resubmit the application. In cases where the required criteria are not met, the application should not be resubmitted.
- Refills: Patients must coordinate with their healthcare provider in order to receive the second six-month supply. If there are no changes to the application or the medication(s) requested from the first six-month supply, the healthcare provider can check "refill" on page 3 of the original application, put a date in the refill box and fax or mail in pages 1 - 3 of the original application. If there are changes to the medication(s) needed, the healthcare provider should make the necessary changes to the original application. The healthcare provider will still mark the refill box and date.
- These forms can be faxed or mailed:
  Fax: 800.554.2660
  Mail: Alcon Cares, Inc. TA-4-13
  6201 South Freeway
  Fort Worth, TX 76134-0450
- Questions about the PAP:
  Phone: 800.222.8103
  Email: Patient.Assistance@Alcon.com

There is no cost to patients or healthcare providers for using this program.

ACI will use and disclose the patient information only as described in this application or with the patient's consent.

Medication for approved patients is shipped to the healthcare provider's office or, in the case of OTC products, the patient may select home delivery.

By completing this application, the patient understands that acceptance into the ACI patient assistance program is based on the information entered onto this form in good faith.

If the patient changes healthcare providers while enrolled in this program, the patient agrees to submit to ACI a new application completed with the new healthcare provider.

If a patient is physically unable to sign the application, it is permissible for someone who holds a Power of Attorney to sign instead.