

**Directory**  
*of Prescription Drug  
Patient Assistance  
Programs*

**1999–2000**

***Ph*ARMA**

## INTRODUCTION

The research-based pharmaceutical industry has had a long-standing tradition of providing prescription medicines free of charge to physicians whose patients might not otherwise have access to necessary medicines.

To make it easier for physicians to identify the growing number of programs available for needy patients, member companies of the Pharmaceutical Research and Manufacturers of America (P/RMA) created this directory. It lists company programs that provide drugs to physicians whose patients could not otherwise afford them. The programs are listed alphabetically by company. Under the entry for each program is information about how to make a request for assistance, what prescription medicines are covered, and basic eligibility criteria.

### ***Common Questions About This Directory***

**Q.** Who determines whether a medication is listed in the P/RMA Directory?

**A.** Pharmaceutical manufacturers who belong to P/RMA decide which medications to list.

**Q.** What does it mean if this Directory does not list a medication?

**A.** If a particular medication is not listed, the drug may not be available under this program or may not be manufactured by a company belonging to P/RMA. P/RMA does not have access to information about indigent programs offered by non-member companies.

**Q.** What are the eligibility criteria for the program? How does one apply?

**A.** Each company determines the eligibility criteria for its program. Eligibility criteria and application processes vary. Basic eligibility criteria are listed in the directory. If you do not find the answer to your question here, you should contact the drug manufacturer directly. Telephone numbers are listed in the directory. For numbers of companies not listed here, consult a *Physician's Desk Reference (PDR)*.

**Q.** Can P/RMA provide products directly to patients and/or health care providers?

**A.** Release of prescription drugs is subject to numerous federal and state laws. P/RMA is not permitted to dispense or ship pharmaceutical products.

While these programs of America's pharmaceutical research companies are indispensable for the neediest patients, they cannot be expected to solve the larger national problem of access to medical care, including prescription drugs. The pharmaceutical industry will continue to work cooperatively with those seeking public and private sector solutions to these larger problems.

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## **ABBOTT LABORATORIES**

### ***Name Of Program***

Uninsured Patient Program

### ***Physician Requests Should Be Directed To***

Abbott Laboratories  
Uninsured Patient Program  
200 Abbott Park Road, D31C, J23  
Abbott Park, IL 60064-6163  
(800) 222-6883 (option 1)

### ***Product(s) Covered By Program***

Depakote, Gabitril, Norvir and Biaxin  
(Biaxin program available to patients w/  
MAC, MAI or HIV)

### ***Eligibility***

Abbott Laboratories uninsured patient program is available to outpatients who do not have insurance reimbursement for prescriptions and are not eligible for governmental assistance programs (i.e., Medicaid, ADAP).

### ***Other Program Information***

The licensed prescribers office contacts Abbott Laboratories to request an application on the behalf of a patient. An application is sent to the prescriber for completion. Upon receipt of a completed application we will send the prescriber notification regarding the patient's eligibility. If approved, medication will only be shipped to the prescriber's office.

## **AGOURON PHARMACEUTICALS, INC.**

### ***Name Of Program***

VIRACEPT® Assistance Program (VAP)

### ***Physician Requests Should Be Directed To***

VIRACEPT® Assistance Program  
(888) 777-6637

### ***Product(s) Covered By Program***

VIRACEPT® (nelfinavir mesylate)

### ***Eligibility***

Eligibility is determined on a case-by-case basis and takes into consideration an individual's circumstances. Potential applicant or representative may contact the VAP at 1-888-777-6637 between 9am and 6pm EST. Applications are mailed to the physician's office.

### ***Other Program Information***

Once eligibility is determined, a monthly supply is sent to the physician's office. Enrollees must re-enroll every four months.

## **ALZA PHARMACEUTICALS**

### ***Name Of Program***

Indigent Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Indigent Patient Assistance Program  
c/o Comprehensive Reimbursement  
Consultants (CRC)  
8990 Springbrook Drive, Suite 200  
Minneapolis, MN 55433  
(800) 577-3788

### ***Product(s) Covered By Program***

Bicitra, Ditropan, Ditropan XL, Elmiron, Mycelex, Neutra-Phos, Neutra-Phos-K, Ocusert, PolyCitra, PolyCitra-K, Progestasert, Testoderm, Urispas

### ***Eligibility***

Eligibility is determined by ALZA Pharmaceuticals and is based on patient's insurance status and income level. Patients must be ineligible for any other third-party reimbursement or support program to apply for the Indigent Patient Assistance Program.

### ***Other Program Information***

The physician must request an Indigent Patient Assistance application from ALZA Pharmaceuticals.

## **AMGEN INC.**

### ***Name Of Program***

SAFETY NET® Program for EPOGEN®

### ***Physician Requests Should Be Directed To***

Amgen SAFETY NET® Program for EPOGEN®  
(800) 272-9376

### ***Product(s) Covered By Program***

EPOGEN® (Epoetin alfa)

### ***Eligibility***

For patients on dialysis only. Amgen's SAFETY NET® Program is designed to assist those patients who are medically indigent (patients may be uninsured or underinsured). Eligibility is based on patient's insurance status and income level. To enroll a patient, providers should contact the Amgen SAFETY NET® Program by calling (800) 272-9376.

### ***Other Program Information***

Providers apply on behalf of the patient. Any dialysis center, physician, hospital or home dialysis supplier may sponsor a patient by applying to the program on his or her behalf. The program is based on a 12-month patient year rather than on a calendar year. Phone-in or written applications are acceptable for program enrollment.

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### ***Name Of Program***

SAFETY NET® Program for INFERGEN®

### ***Physician Requests Should Be Directed To***

Amgen SAFETY NET® Program for INFERGEN®  
(888) 508-8088

### ***Product(s) Covered By Program***

INFERGEN® (Interferon alfacon-1)

### ***Eligibility***

For patients with chronic hepatitis C only. Amgen's SAFETY NET® Program is designed to assist those patients who are medically indigent. Eligibility is based on patient's insurance status and income level. To enroll a patient, the patient or provider should contact the Amgen SAFETY NET® Program by calling (888) 508-8088.

### ***Other Program Information***

Providers may enroll a patient or the patient may enroll him or herself. Any administering physician, hospital, community pharmacy or home health company may sponsor a patient by applying to the program on his or her behalf. The program is based on a 12-month patient year rather than on a calendar year. Phone-in or written applications are acceptable for program enrollment.

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### ***Name Of Program***

SAFETY NET® Program for NEUPOGEN®

### ***Physician Requests Should Be Directed To***

Amgen SAFETY NET® Program for NEUPOGEN®  
(800) 272-9376

### ***Product(s) Covered By Program***

NEUPOGEN® (Filgrastim)

### ***Eligibility***

Amgen's SAFETY NET® Program is designed to assist those patients who are medically indigent (patients may be uninsured or underinsured). Eligibility is based on patient's insurance status and income level. To enroll a patient, providers should contact the Amgen SAFETY NET® Program by calling (800) 272-9376.

### ***Other Program Information***

Providers apply on behalf of the patient. Any administering physician, hospital, home health company, or community pharmacy may sponsor a patient by applying to the program on his or her behalf. The program is based on a 12-month patient year rather than on a calendar year. Phone-in or written applications are acceptable for program enrollment.

## **ASTRAZENECA**

### ***Name Of Program***

AstraZeneca LP Patient Assistance Program

### ***Physician Requests Should Be Directed To***

AstraZeneca Patient Assistance Program  
(800) 355-6044

### ***Product(s) Covered By Program***

ATACAND® (candesartan cilexetil), EMLA® Anesthetic Disc (lidocaine 2.5% and prilocaine 2.5% cream), EMLA® CREAM (lidocaine 2.5% and prilocaine 2.5%), LEXXEL® (enalapril maleate-felodipine ER), PLENDIL® (felodipine), PRILOSEC® (omeprazole), TONOCARD® (tocainide HCl), TOPROL-XL® (metoprolol succinate)

### ***Eligibility***

The AstraZeneca Patient Assistance Program is available to qualified patients with a demonstrated medical and financial need, who have exhausted third-party insurance and/or aid from Medicaid and social agencies, and who do not have other means to pay for their medication.

### ***Other Program Information***

The physician's office must apply on behalf of a patient. An application is mailed to the physician, or other health care professional with prescribing authority, for his/her signature. Upon receipt and approval of a completed application, a three-month supply of medication will be shipped to the physician's office on the patient's behalf in approximately two weeks.

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### ***Name Of Program***

FOSCAVIR® Assistance and Information on Reimbursement (F.A.I.R.)

### ***Physician Requests Should Be Directed To***

State and Federal Associates  
1101 King Street  
Alexandria, VA 22314  
(800) 488-FAIR (3247)  
(703) 683-2239 (fax)

### ***Product(s) Covered By Program***

FOSCAVIR® (foscarnet sodium) Injection

### ***Eligibility***

If the patient is not covered for outpatient prescription drugs under private insurance or a public program, the patient's income must fall below the level selected by the company. If the patient has insurance coverage for outpatient prescription drugs, he or she may be eligible for assistance with deductibles or maximum benefit limits. Eligibility is determined by the company based on income information provided by the physician.

### ***Other Program Information***

Referral must be made by the physician.

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**Name Of Program**

Zeneca Pharmaceuticals Foundation  
Patient Assistance Program

**Physician Requests Should Be Directed To**

Patient Assistance Program  
Zeneca Pharmaceuticals Foundation  
P.O. Box 15197  
Wilmington, DE 19850-5197  
(800) 424-3727

**Product(s) Covered By Program**

ACCOLATE® (zafirlukast) Tablets,  
ARIMIDEX® (anastrozole) Tablets,  
CASODEX® (bicalutamide) Tablets,  
NOLVADEX® (tamoxifen citrate)  
Tablets, SEROQUEL® (quetiapine  
fumarate) Tablets, SORBITRATE®  
(isosorbide dinitrate) Oral Tablets USP,  
SULAR® (nisoldipine) Tablets,  
TENORETIC® (atenolol and  
chlorthalidone) Tablets,  
TENORMIN® (atenolol) Tablets,  
ZESTORETIC® (lisinopril and  
hydrochlorothiazide) Tablets,  
ZESTRIL® (lisinopril) Tablets,  
ZOLADEX® (goserelin acetate  
implant), ZOMIG® (zolmitriptan)  
Tablets

**Eligibility**

Patient applications are evaluated on a case-by-case basis by the Zeneca Pharmaceuticals Foundation. Eligibility is based on income level/assets and absence of outpatient private insurance, third-party coverage, or participation in a public program. Income eligibility is based upon multiples of the U.S. poverty level adjusted for household size.

**Other Program Information**

Reapplication is required every 12 months. A reapplication is automatically sent to enrolled patients. Patient/family members/physician can obtain application forms from the Zeneca Pharmaceuticals Foundation by calling 1-800-424-3727. Physicians also can obtain a packet of applications from their Zeneca sales representative. Enrollment in the program requires a valid Social Security Number. In addition, the dosage of the medication must conform to FDA approved/labeled indications and dosage regimens. A \$5.00 shipping and handling fee in the form of a money order or credit card is required with each prescription for all products except SEROQUEL.

**BAYER CORPORATION  
PHARMACEUTICAL  
DIVISION****Name Of Program**

Bayer Indigent Patient Program

**Physician Requests Should Be Directed To**

Bayer Indigent Program  
P.O. Box 29209  
Phoenix, AZ 85038-9209  
(800) 998-9180

**Product(s) Covered By Program**

Most Bayer pharmaceutical prescription medications used as recommended in prescribing information

### ***Eligibility***

Patient must be a U.S. resident. Physician must certify patient is not eligible for, or covered by, government-funded reimbursement or insurance program for medication; patient is not covered by private insurance; and patient's household income is below federal poverty-level guidelines. Physician must indicate condition for which drug is to be prescribed and certify that drug will be used for indicated use only. Physician must agree to follow patient through therapy. All applications are subject to a case-by-case evaluation by Bayer Corporation.

### ***Other Program Information***

Patient/physician can qualify over the phone by calling (800) 998-9180. If all information needed is obtained over the phone, approval or denial is given immediately. If patient is approved, an application is generated and sent to the physician's office for signatures.

## **BIOGEN, INC.**

### ***Name Of Program***

Avonex<sup>®</sup> Access Program

### ***Physician Requests Should Be Directed To***

Avonex<sup>®</sup> Support Line  
(800) 456-2255

### ***Product(s) Covered By Program***

Avonex<sup>®</sup> (interferon beta-1a)

### ***Eligibility***

Eligibility is based on patient's insurance status and income level.

## **BOEHRINGER INGELHEIM PHARMACEUTICALS, INC.**

### ***Name Of Program***

Partners in Health

### ***Physician Requests Should Be Directed To***

Partners in Health  
Boehringer Ingelheim Pharmaceuticals, Inc. (BIPI)  
P.O. Box 368  
Ridgefield, CT 06877-0368  
(800) 556-8317 (for information and form)

### ***Product(s) Covered By Program***

ALUPENT<sup>®</sup> MDI, ATROVENT<sup>®</sup>, CATAPRES-TTS<sup>®</sup>, COMBIVENT<sup>®</sup>, FLOMAX<sup>®</sup>, MEXITIL<sup>®</sup>, MICARDIS<sup>®</sup>, SERENTIL<sup>®</sup> for FDA-approved indications only

### ***Eligibility***

Eligibility to be determined solely by BIPI. Patient must be a U.S. citizen ineligible for prescription assistance through Medicaid or private insurance. Patient must meet established financial criteria.

### ***Other Program Information***

All requests are reviewed and approved on a case-by-case basis. Application form, prescription, and patient's income documentation are required. Maximum of three months supply may be provided per request. Complete financial re-application is required annually. Renewal requests within the same year require only the application form and a prescription.

Program is subject to change without notice. Current program specifics can be obtained by calling the toll-free number above.

## **BRISTOL-MYERS SQUIBB COMPANY**

### ***Name Of Program***

Bristol-Myers Squibb Patient Assistance Program



***Physician Requests Should Be Directed To***

Bristol-Myers Squibb  
Patient Assistance Program  
P.O. Box 4500  
Princeton, NJ 08543-4500  
Mailcode P25-31  
(800) 332-2056; (609) 897-6859 (fax)

***Product(s) Covered By Program***

Many Bristol-Myers Squibb pharmaceutical products

***Eligibility***

This program is designed to provide temporary assistance to patients with a financial hardship who are not eligible for prescription drug coverage through Medicaid or any other public or private health program. Patients who meet the program's eligibility criteria are provided BMS products free of charge.

***Other Program Information***

Physicians and other health care professionals who are interested in enrolling a patient should call the toll-free number above to request an application form.

**CIBA PHARMACEUTICALS**

(Please see Novartis Pharmaceuticals, page 14).

**DUPONT  
PHARMACEUTICALS  
COMPANY**

***Name Of Program***

DuPont Pharmaceuticals Company  
Patient Assistance Program

***Physician Requests Should Be Directed To***

Michelle Paoli  
DuPont Pharmaceuticals Company  
Chestnut Run Plaza,  
Hickory Run Bldg.  
974 Centre Road  
Wilmington, DE 19805  
(800) 474-2762

***Product(s) Covered By Program***

All marketed non-controlled prescription products

***Eligibility***

Eligibility is based on the patient's insurance status and income level/assets. Patients should have exhausted all third-party insurance, Medicaid, Medicare, and all other available programs. The patient must be a resident of the United States.

***Other Program Information***

The physician should request an application by calling 1-800-474-2762, prompt 5. The physician must complete and sign the physician-designated area of the application and include a signed, completed prescription. The patient must complete and sign the patient-designated area of the application. The application should be mailed to the address above. It takes approximately two weeks from receipt of an approved application for delivery of medication to the physician.

**EISAI INC.**

***Name Of Program***

Aricept® (donepezil HCl)  
Patient Assistance Program

***Physician Requests Should Be Directed To***

The Aricept® Patient Assistance Program (800) 226-2072

***Product(s) Covered By Program***

Aricept® (donepezil HCl) 5mg and 10 mg tablets

### ***Eligibility***

Eisai Inc. and Pfizer Inc have developed the Aricept Patient Assistance Program for those U.S. residents without prescription drug coverage through either public or private insurance. Aricept® will be provided free of charge to patients who meet the following criteria:

Patient has no insurance or other third-party payer prescription drug coverage, including Medicaid coverage or Medicare managed care coverage. Patient's annual income must fall within a predetermined range. Patient must be diagnosed by a physician as having mild to moderate dementia of the Alzheimer's type.

### ***Other Program Information***

Patient must requalify after 90-day initial supply.

## **ELAN PHARMACEUTICALS, INC.**

### ***Name Of Program***

Elan Pharmaceuticals Prescription Assistance Program

### ***Physician Requests Should Be Directed To***

Elan Pharmaceuticals Prescription Assistance Program  
c/o Athena Rx Home Pharmacy  
800 Gateway Boulevard  
South San Francisco, CA 94080  
(800) 528-4362 (patients)  
(800) 621-4835 (physicians/staff only)

### ***Product(s) Covered By Program***

Permax® (pergolide mesylate),  
Zanaflex® (tizanadine hydrochloride),  
Diastat® (diazepam rectal gel),  
Mysoline® (primidone),  
Naprelan® (naproxen sodium)

### ***Eligibility***

The patient must be a resident of the United States, have a net worth less than \$30,000 and no third-party prescription drug coverage.

### ***Other Program Information***

The prescribing physician and patient must provide the following to Athena Rx Home Pharmacy: a letter of denial from the state Medicaid program; the patient's most recent income tax return, three consecutive bank statements or financial statements from the same account; a letter on the physician's letterhead requesting the medication and assurance on financial need; and a prescription for a one-year supply. Once the request is approved, the product will be shipped quarterly to the patient via UPS delivery. New requests must be filed for additional product.

## **FUJISAWA HEALTHCARE, INC.**

### ***Name of Program***

Prograf™ Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Prograf™ Patient Assistance Program  
c/o Medical Technology Hotlines<sup>SM</sup>  
P.O. Box 7710  
Washington, DC 20044-7710  
(800) 4-PROGRAF  
(800) 477-6472, or (202) 393-5563 in the Washington, DC area

### ***Product(s) Covered By Program***

Prograf™ capsules (tacrolimus, FK506)

### ***Eligibility***

Fujisawa Healthcare, Inc. developed the Prograf™ Patient Assistance Program to help improve access to oral Prograf™ for patients who have no health insurance for Prograf™ and limited financial resources. To be eligible for the program, patients must meet income and insurance criteria set by Fujisawa Healthcare. Please call the Prograf™ Reimbursement Hotline (800-4-PROGRAF) for an application or for information about eligibility. If you describe a patient's insurance and financial situation, Hotline staff can determine whether the patient is likely to qualify for the Prograf™ Patient Assistance Program.

### ***Other Program Information***

To enroll a patient, physicians must first register with the program. Registered physicians may enroll patients by submitting a patient enrollment form and a prescription. If approved, the patient will receive two 90-day shipments of Prograf™ from a mailorder pharmacy affiliated with the program. The pharmacy will bill the patient \$20 per shipment for expenses associated with dispensing and shipping the product. If continued assistance is required after six months, the physician must reapply for the patient.

## **GENENTECH, INC.**

### ***Name Of Program***

Uninsured Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Genentech, Inc.  
P.O. Box 2586  
Mail Stop #13  
S. San Francisco, CA 94083-2586  
(800) 879-4747, (415) 225-1366 (fax)

### ***Product(s) Covered By Program***

Activase® (alteplase recombinant), Herceptin® (trastuzumab), Protropin® (somatrem for injection), Nutropin® (somatropin for injection), Nutropin AQ™ (somatropin for injection), Rituxan® (rituximab)

### ***Eligibility***

A completed application form must be submitted for all products and must contain required medical, financial, and insurance information. The required information for Nutropin®, Nutropin AQ™, Protropin®, and Rituxan™ applications is provided by the physician and patient. Required information for Activase® is provided by the hospital. Required information for Rituxan™ is provided by the prescribing physician. For consideration for any of the programs, the patient must not be eligible for public or private insurance reimbursement. Specifically for Activase®, the patient must have an annual gross income of \$25,000 or less. Once patient eligibility has been verified for Nutropin®, Nutropin AQ™, and Protropin®, future shipments will be directed to the physician's office on behalf of the patient. Once patient eligibility has been verified for Activase® and Rituxan™, Genentech will provide replacement of the amount of product used to treat the patient. These programs may be subject to change.

## **GENETICS INSTITUTE, INC.**

### ***Name Of Program***

The BENEFIX Reimbursement and Information Program

### ***Physician Requests Should Be Directed To***

(888) 999-2349

### ***Product(s) Covered By Program***

Benefix™ Coagulation Factor IX (recombinant)

### ***Eligibility***

The program is designed to provide temporary assistance to patients who meet the pre-determined eligibility criteria. Eligible patients must be without prescription drug coverage from a third-party payer. Patients who meet the eligibility criteria are eligible for a period of 90 days, at which time they must requalify for the program.

### ***Other Program Information***

Application forms are sent to physicians who are treating specific patients who may qualify for the program. Application forms must be signed by the patient and physician prior to returning to the program at 1101 King Street, Suite 600, Alexandria, VA 22314.

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### ***Name Of Program***

Neumega® Access Program

### ***Physician Requests Should Be Directed To***

The Neumega® Access Program  
(888) NEUMEGA (638-6342)

### ***Product(s) Covered By Program***

Neumega® (oprelvekin)

### ***Eligibility***

For uninsured and underinsured patients who have limited financial resources.

### ***Other Program Information***

Reimbursement specialists provide assistance to physicians, nurses, office managers, pharmacists and patients with insurance reimbursement, such as information on billing and coding. Service staff will also provide individualized help with claims filing and preauthorization requests and provide support in challenging claim denials.

## **GENZYME CORPORATION**

### ***Name Of Program***

Ceredase® / Cerezyme® Access Program (CAP Program)

*Established by the Genzyme Charitable Foundation*

### ***Physician Requests Should Be Directed To***

Wytske Kingma, M.D.

Medical Affairs

Genzyme Corp.

One Kendall Square

Cambridge, MA 01239-1562

(800) 745-4447, ext. 7808

### ***Product(s) Covered By Program***

Ceredase® (alglucerase injection),

Cerezyme® (imiglucerase for injection)

### ***Eligibility***

Based on financial and medical need.

Must be uninsured and lack the

financial means to purchase the drug.

In order to maintain eligibility, patients

and their families are expected to

continue exploring alternative funding

options with the Genzyme Case

Management Specialist. These options

include private insurance, government

programs and/or charitable sources.

### ***Other Program Information***

The CAP Program is considered a

temporary funding program.

## **GILEAD SCIENCES, INC.**

### ***Name Of Program***

Gilead Sciences Support Services

### ***Physician Requests Should Be Directed To***

Gilead Sciences Support Services

1-800-Gilead 5 (445-3235)

or fax 1-713-760-0049

(9:00 a.m. to 5:30 p.m. Eastern Time)

**Product(s) Covered By Program**

VISTIDE® (cidofovir injection), for the treatment of cytomegalovirus (CMV) retinitis in patients with AIDS

**Eligibility**

Gilead Sciences Support Services is designed to assist both insured and uninsured patients in receiving reimbursement for VISTIDE. To determine eligibility for this program, physicians or patients may request a Patient Assistance Program application for VISTIDE and mail or fax the completed form to Gilead Sciences Support Services.

**Other Program Information**

The Support Services program offers insurance claims assistance, referrals for financial support, referrals to AIDS service agencies. Support specialists consult with insured patients and their physicians regarding prior authorization or third-party insurance claims, contact insurance companies on behalf of patients and contact patients and physicians to offer appeal procedures.

**GLAXO WELLCOME INC.****Name Of Program**

Glaxo Wellcome Patient Assistance Program

**Physician Requests Should Be Directed To**

Glaxo Wellcome Inc.  
Patient Assistance Program  
P.O. Box 52185  
Phoenix, AZ 85072-2185  
(800) 722-9294  
(800) 750-9832 (fax)

*Additional Program Information Can Be Found At:*

[www.glaxowellcome.com/pap](http://www.glaxowellcome.com/pap)  
Program materials may also be ordered by health professionals through this website.

**Product(s) Covered By Program**

All marketed Glaxo Wellcome prescription products

**Eligibility**

Glaxo Wellcome is dedicated to assuring that no one is denied access to our marketed prescription products as a result of an inability to pay. The Patient Assistance Program is intended to serve patients who do not qualify for or have drug benefits through private insurance or government-funded programs. The Patient Assistance Program is not intended to replace government-sponsored programs.

The Patient Assistance Program is designed as an interim solution to assist financially disadvantaged individuals until alternative funding can be found. Income eligibility is based upon multiples of the federal poverty level adjusted for household size. The provision of free medication is a philanthropic activity by Glaxo Wellcome, and therefore, the Patient Assistance Program is considered the payer of last resort.

**Other Program Information**

This program is available only to patients treated in an outpatient setting. All completed applications will be reviewed against the company's established criteria on a case-by-case basis. Enrolled patients are eligible to receive up to 90 continuous days of drug therapy with nominal copayments. Program benefits for outpatient products are provided through pharmacies. Injectable products are provided to the health care provider via direct product shipment.

## **HOECHST MARION ROUSSEL, INC.**

### ***Name Of Program***

Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Patient Assistance Program  
Hoechst Marion Roussel, Inc.  
P.O. Box 9950  
Kansas City, MO 64134-0950  
(800) 221-4025

### ***Product(s) Covered By Program***

All prescription products manufactured by Hoechst Marion Roussel, except Tenuate

### ***Eligibility***

Determined by the physician based on patient's income level and lack of prescription coverage. The intent of the program is to provide access to products for patients who are legal U.S. residents, fall below the federal poverty level and have no other means of prescription coverage, i.e., private or public assistance. The program is restricted to indigent patients.

### ***Other Program Information***

Necessary forms are provided by the company and are sent only to the physician. In most cases, a three-month supply of product is available at any one time.

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### ***Name Of Program***

The Anzement Patient Assistance Program and the Anzement Reimbursement Program

### ***Physician Requests Should Be Directed To***

Anzement Patient Assistance Program  
c/o Comprehensive Reimbursement Consultants (CRC)  
8990 Springbrook Drive, Suite 200  
Minneapolis, MN 55433  
(888) 259-2219

## **JANSSEN PHARMACEUTICA**

### ***Name of Program***

Janssen Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Janssen Patient Assistance Program  
1800 Robert Fulton Drive  
Reston, VA 20191-4346  
(800) 544-2987

### ***Product(s) Covered By Program***

Janssen's medical prescription products

### ***Eligibility***

Program will ensure that all of Janssen's prescription products [Duragesic® (fentanyl transdermal), Ergamisol® (levamisole), Hismanal® (astemizole), Imodium® (loperamide), Nizoral® Cream (ketoconazole cream), Nizoral® Shampoo (ketoconazole shampoo), Nizoral® Tablet (ketoconazole tablet), Propulsid® (cisapride), Sporanox® (itraconazole), Vermox® (mebendazole)] will be free of charge to any persons who meet specific medical criteria and lack financial resources and third-party insurance necessary to obtain treatment. Reimbursement specialist determines eligibility for each patient. Janssen requests that physicians not charge patients beyond insurance coverage for professional services.

### ***Other Program Information***

One or two months' supply available; varies by product.

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### ***Name Of Program***

The Risperdal Patient Assistance Program and The Risperdal Reimbursement Support Program

***Physician Requests Should Be Directed To***

Janssen Cares  
The Risperdal Patient Assistance Program  
4828 Parkway Plaza Blvd., Suite 220  
Charlotte, NC 28217-1969  
(800) 652-6227, Monday through Friday  
(9:00 a.m. to 5:00 p.m. E.T.)  
(704) 357-0036 (fax)

***Eligibility***

Program will ensure that all RISPERDAL® (risperidone) is made available free of charge to any persons who meet specific medical criteria and lack financial resources and third-party insurance necessary to obtain treatment. Reimbursement specialist determines eligibility for each patient. Janssen requests that physicians not charge patients beyond insurance coverage for professional services.

The Risperdal Reimbursement Support Program is designed to answer physicians' and patients' questions and solve problems related to Risperdal reimbursement as efficiently and quickly as possible.

**KNOLL PHARMACEUTICAL COMPANY**

***Name Of Program***

Knoll Indigent Patient Program

***Physician Requests Should Be Directed To***

Knoll Indigent Patient Program  
Knoll Pharmaceutical Company  
3000 Continental Drive, North  
Mount Olive, NJ 07828-1234  
Attn: Telemarketing

***Product(s) Covered By Program***

Isoptin® SR (verapamil HCl), Mavik (trandolapril), Rythmol® (propafenone HCl), Collagenase Santyl, Synthroid® Tablets (levothyroxine sodium, USP), Tarka (trandolapril and verapamil)

***Eligibility***

Physician must submit appropriate documentation proving patient indigence to company.

***Other Program Information***

Decisions are made on a case-by-case basis. Prescription is required for every request. Maximum of three-month supply on any one request.

**LEDERLE LABORATORIES**

(Please see Wyeth-Ayerst Laboratories Indigent Patient Program on page 29.)

**ELI LILLY AND COMPANY**

***Name Of Program***

Lilly Cares

***Physician Requests Should Be Directed To***

Lilly Cares Program Administrator  
Eli Lilly and Company  
P.O. Box 25768  
Alexandria, VA 22313  
(800) 545-6962

***Product(s) Covered By Program***

Most Lilly prescription products and insulins (except controlled substances) are covered by this program. Gemzar® is covered under a separate program.

***Eligibility***

Patients must be U.S. residents. Eligibility is determined on a case-by-case basis in consultation with each prescribing physician. Eligibility is based on the patient's inability to pay and lack of third-party drug payment assistance, including insurance, Medicaid, government-subsidized clinics, and other government, community, or private programs. Inpatients and those who can obtain drug reimbursement from any source are not eligible. Requests for replacement drugs cannot be honored. Medications are provided directly to the

physician for dispensing to the patient. Quantity of supply is dependent upon type of product being prescribed. All Lilly medications must be used as recommended in product labeling.

***Other Program Information***

Forms to qualify a patient for the program will be provided to the physician. On this form, the physician is requested to provide prescription information, including signature and DEA number, and to confirm the patient's ineligibility for other forms of outpatient drug coverage.

Additionally, the patient is requested to provide pertinent information and state financial need.

Subsequent request for same patient requires another prescription and restatement of medical and financial need. Program guidelines may be subject to change.

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***Name Of Program***

Gemzar® Patient Assistance Program

***Physician Requests Should Be Directed To***

Gemzar® Reimbursement Hotline  
(888) 4-GEMZAR (888-443-6927)

***Product(s) Covered By Program***

Gemzar® (gemcitabine hydrochloride)

***Eligibility***

Applications for the program are available by calling the toll-free Gemzar Hotline. Applicants determined to be eligible based on program income criteria will be approved on the basis of these additional criteria: no medical insurance, and ineligible for any programs with a drug benefit provision, including Medicaid, third-party insurance, Medicare, and all other programs have denied coverage for Gemzar in writing, and all appeals have been exhausted.

**THE LIPOSOME COMPANY, INC.**

***Name Of Program***

Financial Assistance Program for ABELCET®

***Physician Requests Should Be Directed To***

Financial Assistance Program for ABELCET®

The Liposome Company, Inc.  
One Research Way  
Princeton, NJ 08540-6619  
(800) 335-5476

***Product(s) Covered By Program***

ABELCET® (amphotericin B lipid complex injection)

***Eligibility***

Patients must be uninsured (not eligible to receive reimbursement through any other third-party drug reimbursement program, i.e., Medicaid, local or federal agency programs, Blue Cross/Blue Shield, private insurance programs and private foundations), and are unable to pay for the product out-of-pocket. Eligibility is determined by The Liposome Company based on medical and financial information provided on behalf of the patient by the hospital or physician.

***Other Program Information***

Patients must receive ABELCET® from a hospital, physician, or home health care company for a medically appropriate application. Providers may enroll a patient by calling (800) 335-5476 or by contacting a Liposome Area Sales Manager to obtain an application form. Application forms must be completed and signed by a physician to enroll a patient.



## **MERCK & CO., INC.**

### ***Name Of Program***

The Merck Patient Assistance Program

### ***Physician Requests Should Be Directed To***

The Merck Patient Assistance Program—Health care professionals with prescribing privileges may call (800) 994-2111

### ***Product(s) Covered By Program***

Most Merck products. Requests for vaccines and injectables are not accepted, with the exception of requests for anti-cancer injectable products.

### ***Eligibility***

The Merck Patient Assistance Program is designed to provide temporary assistance to patients who have no access to any insurance coverage for prescription medications and are *truly* unable to afford prescription medications. The patient must have exhausted all options for prescription benefits and coverage including: private insurance, HMOs, Medicaid, Medicare, state pharmacy assistance programs, Veteran's Assistance, and any other social service agency support. Patients must also reside in the U.S. and have a U.S. treating physician. Completed applications are reviewed on a case-by-case basis.

### ***Other Program Information***

Each application must be completely filled out and signed by both the prescriber and the patient and be mailed with an original, signed, dated prescription with the prescriber's name, address, professional designation, and a DEA or state license number.

Completed applications are reviewed for eligibility on a case-by-case basis. Once eligibility has been verified, up to a three-month supply of the prescribed

medication(s) is sent directly to the prescriber's office for distribution to the patient. Medications are labeled for the patient.

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### ***Name Of Program***

SUPPORT™  
Reimbursement Support and Patient Assistance Services for Crixivan®

### ***Physician Requests Should Be Directed To***

SUPPORT™  
Health care professionals or patients may call (800) 850-3430

### ***Product(s) Covered By Program***

Crixivan® (indinavir sulfate)

### ***Eligibility***

The SUPPORT™ program assists patients who are prescribed Crixivan® and are uncertain of their insurance coverage, in locating payment sources for Crixivan®. Free product is provided to those uninsured patients who qualify, and for whom no alternative source of coverage can be identified. Patients must also reside in the U.S. and have a U.S. treating physician. All applications are reviewed on a case-by-case basis. Product is shipped to the prescriber's office for distribution to the patient. Medicine is labeled for the patient.

## **NOVARTIS PHARMACEUTICALS**

### ***Name Of Program***

Novartis Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Novartis Pharmaceuticals  
Patient Assistance Program  
P.O. Box 52052  
Phoenix, AZ 85072-9170  
(800) 257-3273

### ***Product(s) Covered By Program***

Certain single source and/or life-sustaining products. Controlled substances are not included.

### ***Eligibility***

The Patient Assistance Program provides temporary assistance to patients who are experiencing financial hardship and who have no prescription drug insurance, until alternative sources of funding are obtained. Patients are required to complete an application along with their physicians and return it for evaluation.

### ***Other Program Information***

Patient applications are evaluated on a case-by-case basis. Novartis Pharmaceuticals will be launching a new Patient Assistance Program in January 1998. Please call for information regarding our new procedures or new products sponsored in the program.

## **ORTHO BIOTECH INC.**

### ***Name Of Program***

Procritline™

### ***Physician Requests Should Be Directed To***

Procritline™

1250 Bayhill Drive, Suite 300

San Bruno, CA 94066

(800) 553-3851

(800) 683-7855 (fax)

Hours of operation: 9:00am-8:00pm EST

### ***Product(s) Covered By Program***

PROCRIPT® (Epoetin alfa) for non-dialysis use, LEUSTATIN® (cladribine) Injection

### ***Eligibility***

Program will ensure that PROCRIPT® and/or LEUSTATIN® is made available to any persons who meet specific medical criteria and lack financial resources and third-party coverage necessary to obtain treatment. A reimbursement specialist determines eligibility.

### ***Other Program Information***

Patient eligibility application forms are available by accessing the 800 number (800-553-3851). This call can help determine if a patient is eligible to enroll in the program or is eligible for an alternative program if other sources of funding are identified.

## **ORTHO DERMATOLOGICAL**

### ***Name Of Program***

Ortho Dermatological Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Ortho Dermatological Patient Assistance Program

Ortho-McNeil Patient Assistance Program

P.O. Box 938

Somerville, NJ 08876

(800) 797-7737

### ***Product(s) Covered By Program***

Prescription products prescribed according to approved labeled indications and dosage regimens.

### ***Eligibility***

Patients should not have insurance coverage for prescription medication. Patients should not be eligible for other sources of drug coverage; they need to have applied to public sector programs and been denied. Patients' income falls below poverty level and retail purchase would cause hardship.

### ***Other Program Information***

Health care practitioner should request an application form. The completed form must be accompanied by a signed and dated prescription. Medication will be sent to the health care practitioner for dispensing to the patient.

## **ORTHO-McNEIL PHARMACEUTICAL, INC.**

### ***Name Of Program***

Ortho-McNeil Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Ortho-McNeil Patient Assistance Program  
P.O. Box 938  
Somerville, NJ 08876  
(800) 797-7737

### ***Product(s) Covered By Program***

Prescription products prescribed according to approved labeled indications and dosage regimens

### ***Eligibility***

Patients should not have insurance coverage for prescription medication. Patients should not be eligible for other sources of drug coverage; they need to have applied to public sector programs and been denied. Patients' income falls below poverty level and retail purchase would cause hardship.

### ***Other Program Information***

Health care practitioner should request an application form. The completed form must be accompanied by a signed and dated prescription. Medication will be sent to the health care practitioner for dispensing to the patient.

## **PARKE-DAVIS**

Division of Warner-Lambert Company

### ***Name Of Program***

Parke-Davis Patient Assistance Program

### ***Physician Requests Should Be Directed To***

The Parke-Davis Patient Assistance Program  
P.O. Box 1058  
Somerville, NJ 08876  
(908) 725-1247

### ***Product(s) Covered By Program***

Accupril, Cognex, Dilantin, Loestrin, Neurontin, Rezulin, and Zarontin

### ***Eligibility***

Patients must not be eligible for other sources of drug coverage and must be deemed financially eligible based on company guidelines and physician certification.

### ***Other Program Information***

Physicians should request an application form from their Parke-Davis Sales Representative. The completed form, accompanied by a signed and dated prescription, should be mailed to the address above. Up to a three-month supply will be delivered to the physician for dispensing to the patient.

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### ***Name Of Program***

Lipitor Patient Assistance Program

### ***Physician Requests Should Be Directed To***

The Lipitor Patient Assistance Program  
P.O. Box 1058  
Somerville, NJ 08876  
(908) 218-0120

### ***Product(s) Covered By Program***

Lipitor (atorvastatin calcium)

### ***Eligibility***

Patients must not be eligible for other sources of drug coverage and must be deemed financially eligible based on company guidelines and physician certification.

### ***Other Program Information***

Physicians should request an application form from their Parke-Davis or Pfizer Sales Representative.

The completed form, accompanied by a signed and dated prescription, should be mailed to the address above.

Up to a three-month supply will be delivered to the physician for dispensing to the patient.

## **PASTEUR MÉRIEUX CONNAUGHT**

### ***Name Of Program***

Indigent Patient Program

### ***Physician Requests Should Be Directed To***

Customer Account Management  
Pasteur Merieux Connaught  
Discovery Drive  
Swiftwater, PA 18370-0187  
(800)-VACCINE (800-822-2463)

### ***Product(s) Covered By Program***

IMOVAX® Rabies, rabies vaccine; IMOGAM® Rabies-HT, rabies immune globulin (human) (USP); TheraCys® BCG live intravesical (Note: IMOVAX® and IMOGAM® Rabies-HT are provided on a post-exposure basis only)

### ***Eligibility***

Determined on a case-by-case basis. Limited to those individuals who have been identified as indigent, uninsured, and ineligible for Medicare and Medicaid; is not eligible for other programs offered by the state, county or city; the patient is a U.S. resident; patient's household income is below federal poverty guidelines. Physician must waive all fees associated with treating the patient and certify product will not be sold, traded, or used for any other purpose but to treat the patient applying for assistance.

### ***Other Program Information***

Pasteur Mérieux Connaught reserves the right to modify or discontinue the Indigent Patient Program at any time for any reason. An application form must be completed, call 1-800-VACCINE to receive an application.

Rabies—The physician needs to specify the quantity of IMOGAM® Rabies needed for patient (in mL) as well as the number of doses of IMOVAX® Rabies, along with the patient's age and weight.

TheraCys®—Six doses are provided for one induction course of therapy.

Connaught does provide, under the program, for a full course of therapy—induction and maintenance—which may be as high as 11 doses (six doses for induction plus as many as five doses for maintenance) at the physician's discretion.

## **PFIZER INC**

### ***Name Of Program***

Pfizer Prescription Assistance

### ***Physician Requests Should Be Directed To***

Pfizer Prescription Assistance  
P.O. Box 25457  
Alexandria, VA 22313-5457  
(800) 646-4455

### ***Product(s) Covered By Program***

Most Pfizer outpatient products with chronic indications are covered by this program. Aricept®, Diflucan® and Zithromax® are covered by separate programs.

### ***Eligibility***

Any patient that a physician is treating as indigent is eligible. Patients must have incomes below \$12,000 (single) or \$15,000 (family). Patients must not be receiving or be eligible for third-party or Medicaid reimbursements for medications. No copayment or cost-sharing is required by the patient.

### ***Other Program Information***

Specific forms are not required. The physician must write a letter on his or her letterhead to Pfizer stating that the patient meets income criteria and is uninsured for pharmaceuticals and enclose a prescription for the desired product. The letter must be signed by the prescribing physician. Products are shipped to the physician for redistribution to the patient. Products are supplied to the physician in stock packages, usually 100 tablets or capsules. It may take up to four weeks to receive the product. Refills are obtained through physician resubmission of request. Pfizer reserves the right to limit enrollment of patients.

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### ***Name Of Program***

Diflucan® and Zithromax® Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Diflucan® and Zithromax® Patient Assistance Program  
(800) 869-9979

### ***Product(s) Covered By Program***

Diflucan® (fluconazole) and Zithromax® (azithromycin) for MAC prophylaxis

### ***Eligibility***

Patient must not have insurance or other third-party coverage, including Medicaid, and must not be eligible for a state's AIDS drug assistance program. Patient must have an income of less than \$25,000 a year without dependents, or less than \$40,000 a year with dependents.

### ***Other Program Information***

Physicians should call the Diflucan® and Zithromax® Patient Assistance Program and explain the patient's situation to the Patient Assistance Specialist. The specialist will then send a short qualifying form that requests insurance status, income information, and the amount of Diflucan® or Zithromax® the patient will require. The form must be completed, signed, a prescription attached, and returned to the Patient Assistance Program in the envelope provided.

The Program staff will determine whether the patient is eligible for free Diflucan® or Zithromax® on the same day the form is received. A letter will be sent notifying the physician of the patient's eligibility or ineligibility. It may take up to three weeks from the placement of the first call to the delivery of the product to physicians. Pfizer reserves the right to limit enrollment of patients.

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### ***Name Of Program***

Sharing the Care

### ***Requests Should Be Directed To***

Sharing the Care  
Pfizer Inc  
235 E. 42nd Street  
New York, NY 10017-5755  
(800) 984-1500

### ***Product(s) Covered By Program***

Certain Pfizer single-source products

### ***Eligibility***

The program, a joint effort of Pfizer, the National Governors' Association, and the National Association of Community Health Centers, works solely through community, migrant, and homeless health centers that are funded under section 330(e), 330(g), or 330(h) of the Public Health Service Act and that have an in-house pharmacy. The program

includes the participation of more than 350 health centers throughout the United States. To be eligible to participate in Sharing the Care, the patient must be registered at a participating health center, must not be covered by any private insurance or public assistance covering pharmaceuticals, must not be Medicaid-enrolled, and must have a family income that is equal to or below the federal poverty level. Pfizer reserves the right to limit enrollment of patients and health centers.

**Other Program Information**

Product is dispensed to patient at health center pharmacy.

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**Name Of Program**

Aricept<sup>®</sup> Patient Assistance Program  
(Please see Eisai Inc. on page 6 for complete program information.)

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**Name Of Program**

Lipitor Patient Assistance Program  
(Please see Parke-Davis on page 16 for complete program information.)

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**Name Of Program**

(A Participant in) the Arkansas Health Care Access Program

**Physician Requests Should Be Directed To**

Ms. Pat Keller  
Program Director  
Arkansas Health Care Access  
Foundation  
P.O. Box 56248  
Little Rock, AR 72215  
(800) 950-8233, (501) 221-3033

**Product(s) Covered By Program**

Most Pfizer prescription products are covered

**Eligibility**

Must be an Arkansas resident to qualify. Eligible individuals are certified by the Arkansas Local County Department of Human Services as being Arkansas residents below the federal poverty guidelines, who do not have health insurance benefits and do not qualify for any government entitlement programs. No copayment or cost-sharing is required from the patient. Physician must waive his or her fee for the initial visit. This program does not apply to individuals during hospital inpatient stays.

**Other Program Information**

Physicians should contact the Arkansas Health Care Access Foundation for further information.

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**Name Of Program**

(A Participant in) the Kentucky Health Care Access Program

**Physician Requests Should Be Directed To**

Mr. J. Scott Judy  
Executive Vice President  
Health Kentucky, Inc.  
12700 Shelbyville Road  
Louisville, KY 40243  
(800) 633-8100, (502) 254-4214  
(502) 254-5117 (fax)  
healthky@pop.net (e-mail)

**Product(s) Covered By Program**

Most Pfizer prescription products are covered

***Eligibility***

Must be a Kentucky resident to qualify. Eligible individuals are certified by the Kentucky Cabinet for Health Services as Kentuckians below the federal poverty standards who do not have health insurance benefits and do not qualify for any government entitlement programs. No copayment or cost-sharing is required from the patient. Physician must waive his or her fee. This program does not apply to individuals during hospital inpatient stays.

***Other Program Information***

Physicians should contact Health Kentucky, Inc. for further information.

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***Name Of Program***

(A Participant in) Commun-I-Care

***Physician Requests Should Be Directed To***

Mr. Ken Trogdon  
Director  
Commun-I-Care  
P.O. Box 12054  
Columbia, SC 29211  
(800) 763-0059, (803) 933-9183

***Product(s) Covered By Program***

Most Pfizer prescription products are covered

***Eligibility***

Eligible individuals must be South Carolina residents. Individuals are certified by Commun-I-Care as below the federal poverty line and not covered by any government entitlement programs. No copayment or cost-sharing is required from the patient. Physician must waive his or her fee.

***Other Program Information***

Physicians should contact Commun-I-Care for further information.

**PHARMACIA & UPJOHN, INC.**

***Name Of Program***

RxMAP Prescription Medication Assistance Program

***Physician Requests Should Be Directed To***

RxMAP  
P.O. Box 29043  
Phoenix, AZ 85038  
(800) 242-7014

***Product(s) Covered By Program***

Numerous products

***Eligibility***

Based on federal poverty level and no prescription drug coverage.

***Other Program Information***

All inquiries should go to RxMAP at (800) 242-7014.

**PROCTER & GAMBLE PHARMACEUTICALS, INC.**

***Physician Requests Should Be Directed To***

Procter & Gamble Pharmaceuticals, Inc.  
P.O. Box 231  
Norwich, NY 13815  
Attn: Customer Service Department  
(800) 448-4878

***Product(s) Covered By Program***

Actonel 30mg, Alora, Asacol, Dantrium Capsules, Didronel, Helidac, Macrochantin, Macrobid

### ***Eligibility***

Procter & Gamble Pharmaceuticals has always tried to ensure that all patients have full access to its products. To qualify, patients should not have insurance coverage for prescription medicines or Medicaid reimbursements. The intent of the program is to assure access to products for patients who fall below the federal poverty level and have no other means of health care coverage. Each patient's case is handled strictly on an individual basis.

The company relies on the physician's assessment of need to determine eligibility. Application forms are provided by the company for the physician/patient to complete.

An original prescription duly signed by the attending physician for one of the company's products is required.

### ***Other Program Information***

The quantity of product supplied depends on diagnosis and need, but generally a three month supply is provided for a chronic medication. Refills require a new prescription and application form from the physician. The prescription medication is sent directly to the physician, who provides it to the patient. Applications are good for one year. Afterwards, patients must be re-screened to ensure continued eligibility.

## **RHÔNE-POULENC RORER INC.**

### ***Name Of Program***

Rhône-Poulenc Rorer Patient Assistance Program

### ***Physician Requests Should Be Directed To***

Medical Affairs / Patient Assistance Program  
Rhône-Poulenc Rorer Inc.  
P.O. Box 5094, 500 Arcola Road  
Mailstop #4C29  
Collegeville, PA 19426-0998  
(610) 454-8110, (610) 454-2102 (fax)

### ***Product(s) Covered By Program***

All products are included, with some limitations

### ***Eligibility***

Rhône-Poulenc Rorer's (RPR) Patient Assistance Program is administered on a case-by-case basis. A patient is eligible to apply to the program if there is a medical and financial need for assistance as identified by a physician, social agent or agency, and if the effort to obtain assistance from all third-party payers, Medicaid, Medicare, and other local, state or federal government support has been exhausted. The physician is requested to fill out a form provided by RPR and to send the completed form along with a valid prescription to the above address. Determination of eligibility is made by the company based on the information in the completed form. Once eligibility has been determined, the prescribed medication is sent to the physician for dispensing to the patient.

### ***Other Program Information***

Subsequent requests for the same patient require an additional prescription and completion of the Patient Assistance Form for confirmation that the patient's status has not changed. Photocopies are not acceptable. This program will continue to be reviewed and modifications will be made to meet the changes occurring in the health care environment as related to the needs of indigent patients.



## **ROCHE LABORATORIES, INC.**

A Division of Hoffmann-La Roche Inc.  
Roche Products Inc.

### ***Name Of Program***

Roche Medical Needs Program

### ***Physician Requests Should Be Directed To***

Roche Medical Needs Program  
Roche Laboratories, Inc.  
340 Kingsland Street  
Nutley, NJ 07110  
(800) 285-4484

### ***Product(s) Covered By Program***

Roche product line with some exceptions

### ***Eligibility***

The Roche Medical Needs Program is designed as an interim solution for patients who lack third-party outpatient prescription drug coverage under private insurance, government-funded programs (Medicaid, Medicare, Veterans Affairs, etc.), or private/community sources and are unable to afford to purchase our products on their own.

Roche offers the Medical Needs Program as a philanthropic endeavor to assure access to Roche products for needy patients at no charge until alternative funding can be found. The Roche Medical Needs Program is part of Roche's commitment to assure access to our products and is not intended to supplant or replace prescription drug coverage provided by third-party public or private payers.

This program is for individual outpatients who meet the Medical Needs Program criteria and is offered through licensed practitioners. The program is not intended for clinics, hospitals, and/or other institutions.

### ***Other Program Information***

Roche Medical Needs Program forms obtained from the Medical Needs Department are required. Applications are provided only to licensed practitioners. Physicians' and patients' signatures and a DEA number are required on the application. A new application form must be completed for patients requiring refills. All completed applications will be reviewed and approved by Roche on a case-by-case basis using the established criteria of the program. Patients and providers may be requested to participate in reimbursement case management based on the product requested. Up to a three-month supply of product will be shipped directly to the licensed practitioner within two to three weeks.

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### ***Name Of Program***

Roche Medical Needs Program for CellCept® (mycophenolate mofetil), CYTOVENE® (ganciclovir capsules), and CYTOVENE®-IV (ganciclovir sodium for injection)

### ***Physician Requests Should Be Directed To***

Roche Transplant Reimbursement Hotline  
(800) 772-5790

### ***Product(s) Covered By Program***

CellCept® (mycophenolate mofetil), CYTOVENE® (ganciclovir capsules), and CYTOVENE®-IV (ganciclovir sodium for injection). CYTOVENE products for use with transplant patients

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**Name Of Program**

Roche Medical Needs Program for FORTOVASE™ (saquinavir), INVIRASE® (saquinavir mesylate), CYTOVENE® (ganciclovir capsules), CYTOVENE®-IV (ganciclovir sodium for injection), and HIVID® (zalcitabine)

**Physician Requests Should Be Directed To**

Roche HIV Therapy Assistance Program  
(800) 282-7780

**Product(s) Covered By Program**

FORTOVASE™ (saquinavir), INVIRASE® (saquinavir mesylate), CYTOVENE® (ganciclovir capsules), CYTOVENE®-IV (ganciclovir sodium for injection), and HIVID® (zalcitabine). CYTOVENE products for use with HIV/AIDS patients

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**Name Of Program**

Roche Medical Needs Program for Roferon®-A (Interferon alpha-2a, recombinant), Vesanoïd® (tretinoin), and Fluorouracil Injection

**Physician Requests Should Be Directed To**

Oncoline™/Hepline™ Reimbursement Hotline  
(800) 443-6676 (press 2 or 3)

**Product(s) Covered By Program**

Roferon®-A (Interferon alpha-2a, recombinant), Vesanoïd® (tretinoin), and Fluorouracil Injection

**ROXANE LABORATORIES, INC.****Name Of Program**

Patient Assistance Program

**Physician Requests Should Be Directed To**

Nexus Healthcare  
4161 Arlingate Plaza  
Columbus, OH 43228  
(800) 274-8651

**Product(s) Covered By Program**

Duraclon; Marinol® (dronabinol) Capsules 2.5 mg; Oramorph SR® (morphine sulfate sustained release) Tablets 15 mg, 30 mg, 60 mg, and 100 mg; Roxanol™ (morphine sulfate concentrated oral solution) 20 mg/ml and 120 ml bottles; Roxanol 100™ (morphine sulfate concentrated oral solution) 100 mg/5 ml and 240 ml bottles; Roxicodone (oxycodone) Tablets 5 mg; Oral solution 5 mg/5 ml; Roxicodone Intensoïl™ 20 mg/ml; Viramune® (nevirapine)

**Eligibility**

Product will be provided free of charge to patients through their pharmacist, provided the patient is uninsured and meets annual income requirements.

**Other Program Information**

Physicians should call the toll-free number to discuss their patient's eligibility with a program representative. If the patient appears to meet the eligibility requirements, a Qualification Form will be mailed to the physician. If eligible, patients can obtain their Duraclon, Marinol®, Oramorph SR®, Roxanol™, Roxicodone, or Viramune® therapies through a participating pharmacy.

## **SANDOZ PHARMACEUTICAL CORPORATION**

(Please see Novartis Pharmaceuticals, page 14).

## **SANOFI PHARMACEUTICALS**

### ***Name Of Program***

Needy Patient Program

### ***Physician Requests Should Be Directed To***

Sanofi Pharmaceuticals  
Needy Patient Program  
c/o Product Information Department  
90 Park Avenue  
New York, NY 10016  
(800) 446-6267

### ***Product(s) Covered By Program***

Aralen,<sup>®</sup> Breonesin,<sup>®</sup> Danocrine,<sup>®</sup> Drisdol,<sup>®</sup> Hytakerol,<sup>®</sup> Mytelase,<sup>®</sup> NegGram,<sup>®</sup> pHisoHex,<sup>®</sup> Plaquenil,<sup>®</sup> Primaquine,<sup>®</sup> Hyalgan,<sup>®</sup> Photofrin,<sup>®</sup> Primacor,<sup>®</sup> and Skelid<sup>®</sup> eligibility determined on a financial case-by-case basis.

### ***Other Program Information***

The physician's office should contact the Sanofi Pharmaceuticals Product Information Department to apply on behalf of a patient. An application is sent to the physician's office for completion and signature, in addition to a signed prescription. Upon receipt of completed application and prescription from physician, and upon approval of application, medication will be shipped directly to the physician's office from the distribution center, in approximately four to six weeks. Each physician is allowed to enroll six patients per year. Each patient can receive a 3-month supply of medication, with an option of one refill for an additional three months supply for a total of six months medication for one year. The physician must contact Sanofi's office for the refill.

## **SCHERING LABORATORIES/KEY PHARMACEUTICALS**

### ***Name Of Program***

Commitment to Care

### ***Physician Requests Should Be Directed To***

*For Intron A/Eulexin:*  
(800) 521-7157

*For Other Products:*  
Schering Laboratories/  
Key Pharmaceuticals  
Patient Assistance Program  
P.O. Box 52122  
Phoenix, AZ 85072  
(800) 656-9485

### ***Product(s) Covered By Program***

Most Schering/Key prescription drugs

### ***Eligibility***

The program is designed to assist those patients who are truly in need—indigent—who are not eligible for private or public insurance reimbursement and who cannot afford treatment. Patient eligibility is determined on a case-by-case basis based upon economic and insurance criteria. Eligibility criteria are currently being reevaluated and may be subject to change.

### ***Other Program Information***

Physician and patient complete an application form. Application is reviewed on a case-by-case basis. Repeat requests require a new application form to be completed.

## SEARLE

### **Name Of Program**

Patients in Need®

### **Physician Requests Should Be Directed To**

Administrator

Searle Patients in Need® Foundation

5200 Old Orchard Road

Skokie, IL 60077

(800) 542-2526, (847) 581-6633 (fax)

or

Local Searle Sales Representative

### **Product(s) Covered By Program**

*Antihypertensives:* Aldactazide®

(spironolactone with

hydrochlorothiazide), Aldactone®

(spironolactone), Calan® SR (verapamil

HCl) sustained-release, Kerlone®

(betaxolol HCl)

*Antihypertensive/Anti-Anginal/Anti-*

*arrhythmic:* Calan® (verapamil HCl),

Covera-HS™ (verapamil HCl)

*Antiarrhythmics:* Norpace® (disopyramide

phosphate), Norpace® CR

(disopyramide phosphate) extended-

release

*Prevention of NSAID-induced gastric ulcers:*

Arthrotec® (diclofenac

sodium/misoprostol), Celebrex™

(celecoxib), Cytotec® (misoprostol)

### **Eligibility**

The physician is the sole determinant of a patient's eligibility for the program based on medical and economic need.

Searle provides guidelines for physicians to consider, but they are not requirements. Searle does not review

documentation for eligibility. The guidelines suggest that: patient suffers

from conditions for which a Searle product in the Patients in Need®

program may be appropriate; patient does not qualify for outpatient

prescription drugs under private insurance, a public program, or other

assistance that pays in whole or in part for prescription drugs; patient's income

falls below a level suggested by Searle.

### **Other Program Information**

Patients in Need® program certificates for free Searle medications are made available to physicians. The physician gives the patient the prescription for an appropriate Searle medication along with a certificate for the Patients in Need® program. The patient then takes the prescription and the certificate to the pharmacy of his/her choosing, and the pharmacist dispenses the prescription to the patient free of charge. The pharmacist submits the certificate to Searle and is reimbursed by Searle.

## SERONO LABORATORIES, INC.

### **Name Of Program**

Connections for Growth

### **Physician Requests Should Be Directed To**

Jack Domieschel

Executive Director, Corporate

Communications

Serono Laboratories, Inc.

100 Longwater Circle

Norwell, MA 02061

(617) 982-9000, (617) 982-1369 (fax)

### **Product(s) Covered By Program**

Saizen® (somatropin [rDNA origin] for injection) for treatment of pediatric growth hormone deficiency

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### **Name Of Program**

Serono Laboratories' Helping Hands Program

### **Physician Requests Should Be Directed To**

Helping Hands Program

Serono Laboratories, Inc.

100 Longwater Circle

Norwell, MA 02061

(617) 982-9000 ext. 5522,

(617) 982-1369 (fax)

**Product(s) Covered By Program**

Fertinex™ (urofollitropin for injection, purified), Gonol-F (follitropin alfa for injection) for treatment of infertility

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**Name Of Program**

Patient Assistance Program

**Physician Requests Should Be Directed To**

Jack Domieschel  
Executive Director, Corporate Communications  
Serono Laboratories, Inc.  
100 Longwater Circle  
Norwell, MA 02061  
(617) 982-9000, (617) 982-1369 (fax)

**Product(s) Covered By Program**

Serostim™ (human growth hormone [rDNA origin]) for treatment of AIDS wasting

**SIGMA-TAU PHARMACEUTICALS, INC.**

**Name Of Program**

NORD/Sigma-Tau Carnitor®  
Drug Assistance (CDA) Program

**Physician Requests Should Be Directed To**

Carnitor® Drug Assistance Program  
c/o NORD  
P.O. Box 8923  
New Fairfield, CT 06812-8923  
(800) 999-NORD

**Product(s) Covered By Program**

Carnitor® (levocarnitine)

**Eligibility**

All applicants must be citizens or permanent residents of the United States. Eligibility is determined by medical and financial criteria and applied to a cost-share formula. A patient applying for eligibility under the CDA Program must first demonstrate having a legal prescription

for Carnitor®. Second, the applicant must prove financial need above and beyond the availability of federal and state funds, private insurance or family resources.

If an applicant is a minor or an adult dependent, NORD may request financial information of family members or guardians before determining the applicant's eligibility.

Applications must be submitted annually to determine continued medical and financial eligibility. Acceptance into the program at any time does not guarantee ongoing eligibility, nor does it mean that applicants are entitled to or will be granted benefits at a later time.

**Other Program Information**

Generally, a patient over 18 years of age may submit his or her own application. If the patient is an adult under the guardianship of another adult, or is a minor, the patient and his/her guardian or parents must jointly submit an application. Applications are reviewed throughout the year. One application per patient, per year, will be accepted. In the event of a significant change in a patient's circumstances, a second application may be considered.

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**Name Of Program**

NORD/Sigma-Tau Matulane® Patient Assistance Program

**Physician Requests Should be Directed To**

Matulane® Patient Assistance Program  
c/o NORD  
P.O. Box 8923  
New Fairfield, CT 06812-8923  
(800) 999-NORD

**Product(s) Covered By Program**

Matulane® (procarbazine hydrochloride)

### ***Eligibility***

All applicants must be medically eligible for Matulane by having a diagnosis of Stage III or IV Hodgkin's disease documented by the treating physician, or any other lymphomas where a physician feels a response is possible. All applicants must be a U.S. citizen or a permanent U.S. resident. All applicants must sign waivers and release of liability forms. The patient is responsible for shipping and handling costs incurred. Applicants must prove financial need above and beyond the availability of federal and state funds, private insurance or family resources.

### ***Other Program Information***

One application will cover the duration of the therapy regimen that is prescribed by the treating physician. This therapy is used in conjunction with certain other anticancer drugs for the treatment of Stage III and IV Hodgkin's disease.

## **SMITHKLINE BEECHAM PHARMACEUTICALS**

### ***Name Of Program***

SB Access to Care Program

### ***Physician Requests Should Be Directed To***

Access to Care Program  
SmithKline Beecham  
One Franklin Plaza-FP1320  
Philadelphia, PA 19101  
(800) 546-0420

### ***Product(s) Covered By Program***

Most SmithKline Beecham outpatient prescription products are covered. Controlled substances and vaccines are not covered. Kytril, Hycamtin and Paxil are covered under separate Access to Care programs. (See listings.)

### ***Eligibility***

Patient's annual household income is less than \$25,000. Patient has no medical insurance and is ineligible for government (e.g., Medicare) or private programs that cover the cost of prescription pharmaceuticals. Patient is a resident of the United States.

### ***Other Program Information***

Physicians are required to submit forms to enroll patients in the program. Product should be prescribed according to approved labeled indications and dosage regimens. All requests must be physician initiated and be submitted on an original SB Access to Care application form. Photocopies of the application form are not acceptable. Both physician and patient must certify that program guidelines are being observed. Quantity of product sent is dependent upon type of product prescribed. Reapplications are required. Product will be sent to the requesting physician and receipt must be verified by signature. Third-party requests will not be honored.

SB reserves the right to change program guidelines without notification.

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### ***Name Of Program***

Oncology Access to Care Program

### ***Physician Requests Should Be Directed To***

The Oncology Access to Care Hotline  
(800) 699-3806

### ***Product(s) Covered By Program***

Kytril (granisetron HCl) and Hycamtin (topotecan HCl)

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### ***Name Of Program***

Access to Care Paxil Certificate Program

***Physician Requests Should Be Directed To***

Access to Care Paxil Certificate Hotline  
(800) 729-4544

***Product(s) Covered By Program***

Paxil® (paroxetine HCl)

**SOLVAY  
PHARMACEUTICALS, INC.**

***Name Of Program***

Patient Assistance Program

***Physician Requests Should Be Directed To***

Solvay Pharmaceuticals, Inc.  
c/o Phoenix Marketing Group  
One Phoenix Drive  
Lincoln Park, NJ 07035  
(800) 788-9277

***Product(s) Covered By Program***

CREON® 5 Capsules (Solvay 1205);  
CREON® 10 Capsules (Solvay 1210);  
CREON® Capsules (Solvay 1220);  
ESTRATAB® (esterified estrogens  
tablets, USP) 0.3 mg (Solvay 1014);  
ESTRATAB® (esterified estrogens  
tablets, USP) 0.625 mg (Solvay 1022);  
ESTRATEST® (esterified estrogens  
and methyltestosterone) Tablets  
(Solvay 1026); ESTRATEST® HS  
(esterified estrogens and methyl-  
testosterone) Tablets (Solvay 1023);  
LITHOBID® (lithium carbonate, USP)  
Tablets 300 mg (Solvay 4492);  
LUVOX® (fluvoxamine maleate)  
Tablets, 25 mg (Solvay 4202); LUVOX®  
(fluvoxamine maleate) Tablets, 50 mg  
(Solvay 4205); LUVOX® (fluvoxamine  
maleate) Tablets, 100 mg (Solvay  
4210); Advanced Formula ZENATE®  
Prenatal Multivitamin/ Mineral  
Supplement Tablets (Solvay 1148);  
PROMETIZIUM® Capsule SV;  
ROWASA® Enema (Solvay 1924);  
ROWASA® Suppository (Solvay 1928)

***Eligibility***

The patient's eligibility is determined on a case-by-case basis in consultation with each prescribing physician and is based on a patient's inability to pay, lack of insurance, and ineligibility for Medicaid. The patient must be a resident of the United States. The physician is encouraged to waive his or her fee. The free product must be provided to the patient for whom it is requested.

***Other Program Information***

Physicians apply on behalf of the patient by submitting a written request on a request form. Blank request forms can be obtained by writing to Solvay Pharmaceuticals, Inc., or by calling the Patient Assistance Program Message Center at (800) 788-9277. Ongoing patient participation is available based on continued medical and financial need. The medication is sent directly to the physician, who provides it to the patient.

**3M PHARMACEUTICALS**

***Name Of Program***

Indigent Patient Pharmaceutical  
Program

***Physician Requests Should Be Directed To***

Medical Services Department  
275-2E-13, 3M Center  
P.O. Box 33275  
St. Paul, MN 55133-3275  
(800) 328-0255, (651) 733-6068 (fax)

***Product(s) Covered By Program***

Most drug products sold by 3M  
Pharmaceuticals in the United States

***Eligibility***

Patients whose financial and insurance circumstances prevent them from obtaining 3M Pharmaceuticals drug products considered to be necessary by their physicians. Consideration is on a case-by-case basis.

## **WYETH-AYERST LABORATORIES**

### ***Name Of Program***

Norplant Foundation

### ***Physician Requests Should Be Directed To***

The Norplant Foundation  
P.O. Box 25223  
Alexandria, VA 22314  
(703) 706-5933

### ***Product(s) Covered By Program***

The Norplant® (levonorgestrel implants) five-year contraceptive system

### ***Eligibility***

Determined on a case-by-case basis and limited to individuals who cannot afford the product and who are ineligible for coverage under private and public sector programs.

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### ***Name Of Program***

Rheumatoid Arthritis Assistance Foundation

### ***Physician Requests Should Be Directed To***

Rheumatoid Arthritis Assistance Foundation  
P.O. Box 766  
Washington, DC 20077-1207  
(800) 282-7704, (888) 508-8083 (fax)

### ***Product(s) Covered By Program***

ENBREL® (etanercept)

### ***Eligibility***

To qualify for assistance, patients or providers should contact 1-800-282-7704 and staff will screen patients for eligibility over the phone. If the patient appears to qualify, an application will be mailed directly to the patient. Eligibility criteria are subject to change without notice.

### ***Other Product Information***

The Rheumatoid Arthritis Assistance Foundation was established to improve access to ENBREL® for patients who have limited resources. To be eligible for assistance, patients must meet the criteria set by the Foundation Board of Directors. Please call 1-800-282-7704 for more information or to discuss eligibility.

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### ***Name Of Program***

Wyeth-Ayerst Laboratories Indigent Patient Program

### ***Physician Requests Should Be Directed To***

John E. James  
Professional Services IPP  
31 Morehall Road  
Frazer, PA 19355

### ***Product(s) Covered By Program***

Various products (not including schedule II, III, or IV products)

### ***Eligibility***

Limited to individuals, on a case-by-case basis, who have been identified by their physicians as "indigent," meaning:

- Low or no income
- Not covered by any third-party agency

### ***Other Product Information***

The program is accessed by physicians whose patients meet the eligibility requirements. A three-month supply of specific products is provided directly to the physician for dispensing to the patient. The patient's signature is required on the application form.

## **ZENECA PHARMACEUTICALS**

(Please see AstraZeneca, p. 3)





**PhRMA**

Pharmaceutical Research and Manufacturers of America  
1100 Fifteenth Street, N.W.  
Washington, DC 20005