Boehringer Ingelheim Cares Foundation

Patient Assistance Program

Mail to: Boehringer Ingelheim Cares Foundation, Inc.
PO Box 66745
St. Louis, MO 63166-6745
Telephone: 1-800-556-8317
Hours of Operation: Monday – Friday 7:30 am – 5:00 pm CST
Fax: 1-866-851-2827

Please Note…Only faxes sent from the prescribing physician's office along with physician's fax cover sheet and fax banner can be accepted.

Application Instructions

Patients wishing to be considered for eligibility must submit a fully completed application along with:

- ☐ Current proof of income (See Section 3 below)
- ☐ Original valid prescription(s) with physician signature
- ☐ Other applicable documentation

All supporting documentation must be included with the application in order to be reviewed

Section 1. Prescribing Healthcare Provider Information:
All fields in the physician information section must be completed. (Note: The physician signature on the prescription must match the signature of Prescribing HealthCare Provider on the application.)

Section 2. Patient Information:
All fields in the patient information section must be completed. Enter N/A where appropriate.

Section 3. Financial Information:
Patients must list all sources of current income and attach documentation as described below.
Please attach a copy of the patient's most recent federal income tax return.
The program accepts copies of all IRS Forms, including but not limited to: All 1040 and 1099 tax forms as well as unemployment statements that display gross income. (Must send all pages)

If the patient has not filed a federal income tax return in the previous sixteen (16) months, please submit a copy of each of the following that apply (Each item provided must represent at least one full month of income):

IRS Form 4506T
W-2 Tax Statement
Pension Statements
Disability Statements
Social Security Checks/Statements
Railroad Retirement Statements
Paycheck stubs (must include name/ID, frequency)
Statements of Interest, Dividends or other Income
Alimony

Section 4. Insurance Information:
Patients must answer all questions in this section.

****If the patient has applied for the Medicare Part D Low Income Subsidy (also known as "Extra Help") through the Social Security Administration within the past year and has been denied, please attach a copy of the denial letter.**

Section 5. Patient Attestation and Signature (required)
Patient signature is required for eligibility determination.

The following medications are available through the program.

Aptivus®	**Jardiance®**	**Stiolto Respimat®**
Atrovent HFA®	**Jentadueto®**	**Striverdi® Respimat®**
Combivent® Respimat®	**Ofev® (Separate application required)**	**Synjardy®**
Gilotrif® (Separate application required)	**Pradaxa®**	**Tradjenta®**
Glyxambi®	**Spiriva Handihaler® & Spiriva Respimat®**	**Viramune XR®**

Medications available on the program are subject to change.

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PRESCRIBING HEALTHCARE PROVIDER INFORMATION – Viramune XR and Aptivus are always shipped to prescribing healthcare provider. All other products will be shipped directly to patient's home.

Physician Name:	**DEA/State License No:**
Address:	
City:	**State:** / **Zip:**
Phone: ( )	**Fax: ( )**

To the best of my knowledge, this patient does not have prescription coverage (other than Medicare Part D) for the prescription attached. I verify that to the best of my knowledge that the information provided here and any additional information required is complete and accurate. I certify that I will not seek payment for any medication dispensed from this program.

Original Signature of Prescribing Healthcare Provider Required ***(Must match signature on prescription)*** **X**	**Date:**

PATIENT INFORMATION

Patient Name:			**SSN/ID No:**
Patient Shipping Address: (Street Address Required)			**Date of Birth:**
City:		**State:**	**Zip:**
Phone Number: ( )	**Gender:** ❑ **Male** ❑ **Female**	**Number of people in household (including self)?**	**US Resident?** ❑ **Yes** ❑ **No**
Are you a Veteran of the US Armed Forces? ❑ **Yes** ❑ **No**	**Have you received disability payments from Social Security for more than 24 months?** ❑ **Yes** ❑ **No**		

Product being Requested:	**Allergies:**	**Other Medications:**

FINANCIAL INFORMATION- Attach a copy of your most recent federal tax return or other acceptable financial documentation. Bank Statements are not accepted.
Must Include supporting documentation for ALL members of household, if applicable. Examples of Acceptable Financial Documentation: IRS forms 1040, 1040EZ, 1040X, 1099.

List all sources, Gross Monthly Amounts

Salary/Wages	$ _____	Social Security	$_____
Disability	$ _____	Pension/Retirement	$_____
Alimony/Child Support	$_____	Unemployment/Work Comp	$_____

Total Gross Household Monthly Income: $_____
Total Patient Household Assets (excludes first home and car): $_____

ATTACH PROOF OF INCOME
(Do Not Send Original Documents)

INSURANCE INFORMATION (Include front and back copy of insurance card, if applicable)

PLEASE ANSWER ALL QUESTIONS BELOW:

Do you have Medicaid? ❑ Yes ❑ No	**Do you have Medicare Part D?** ❑ Yes ❑ No
Do you have Medicare? ❑ Yes ❑ No	**What is your Medicare Number?**

IF YOU HAVE A MEDICARE CARD, PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE CARD

Have you received a denial letter from Low Income Subsidy? If yes, please attach a recent copy of this letter along with your application

Do you Receive VA Benefits? ❑ Yes ❑ No	**AIDS Drug Assistance Program?** ❑ Yes ❑ No	**State Elderly Drug Assistance?** ❑ Yes ❑ No
Do you have Private Prescription Drug Coverage? ❑ Yes ❑ No	**If yes, What is the name of the drug coverage plan?**	

PATIENT ATTESTATION AND SIGNATURE

I certify that the information provided here and any subsequent information I provide is complete, truthful and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. The Boehringer Ingelheim Cares Foundation, Inc. ("BI Cares") is not obligated to verify any of the information contained in Section 1 above or to confirm other medications that I am taking.

I hereby authorize my health plans, physicians, and pharmacy providers to disclose to BI Cares and its affiliates, agents, representatives and service providers ("Recipients"), and authorize the Recipients to access, obtain, use, disclose or receive, my individually identifiable health information, which may include information related to my medical condition, treatment, care management, health insurance, and prescriptions. I understand that this authorization is voluntary, but that if I do not sign it, I may not be able to receive services from BI Cares. I understand that information released under this authorization may no longer be protected by state and federal law. Recipients may use, and disclose to appropriate organizations, my information as necessary to process this application, assist in the identification of other patient assistance resources, verify the information provided in this application, and report information to Boehringer Ingelheim and its affiliates, agents, representatives, and service providers. I understand that I may withdraw my authorization in writing by contacting BI Cares at any time, except to the extent that action has already been taken in reliance on this authorization. I understand that if I do not withdraw my authorization, this authorization will be in effect for one year from the date of enrollment if approved for the program. I understand that my pharmacy may receive compensation in exchange for reports containing my information.

Signature of Patient or Power of Attorney (*Required to process application*) **If signing as POA, please send legal document.** **X**	**Date:**