Mail to: Gilotrif® Patient Assistance Program
PO Box 66982
St. Louis, MO 63166-6982
Telephone: 1-877-814-3915
Fax: 1-866-240-4556
Hours of Operation:
Monday – Friday 7:30 am – 5:00 pm CST

SolutionsPlus
Patient support. Our priority.™

Boehringer Ingelheim Cares Foundation

Application Instructions

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

- ☐ Proof of income
- ☐ **Original valid prescription(s) with physician signature**
- ☐ Any other applicable documentation

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

Section 1. Prescribing Healthcare Provider Information:
All physician information must be completed.

Section 2. Patient Information:
All patient information must be completed. All fields are required.

Section 3. Financial Information:
Patients must list all sources of income and attach documentation as described below.
Please attach a copy of the patient's most recent federal income tax return or other acceptable financial documentation.

If the patient has not filed a federal income tax return in the previous sixteen (16) months, please submit a copy of any one of the following that apply:

- ☐ IRS Form 4506T
- ☐ W-2 Tax Statement
- ☐ Pension Statements
- ☐ Disability Statements
- ☐ Social Security Checks/Statements
- ☐ Railroad Retirement Statements
- ☐ Paycheck stubs
- ☐ Statements of Interest, Dividends or other Income (1099-INT, 1099, 1099T, 1099DIV)

Section 4. Insurance Information:
Patients must complete 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)
Original Patient signature is required for eligibility determination.

Please check the box(s) indicating the patient's medication for which you are seeking assistance:

- ☐ **Gilotrif®**

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PRESCRIBING HEALTHCARE PROVIDER INFORMATION –All products will be shipped directly to patient's home unless otherwise directed.

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

To the best of my knowledge, this patient has no coverage (including Medicare, Medicaid, VA or any other public programs) for this prescription. I verify that to the best of my knowledge the information provided is complete and accurate.

Original Signature of Prescribing Healthcare Provider *(Required to process application)* **X**	**Date**

PATIENT INFORMATION

Patient Name:			**SSN/ID No:**
Patient Shipping Address: (Street Address Required)			
City:		**State:**	**Zip:**
Phone: ( )	**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

PATIENT ATTESTATION AND SIGNATURE

I certify that this information is complete 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. I hereby authorize the Boehringer Ingelheim CARES Foundation, Inc., a patient assistance program, or PAP, to obtain and disclose information from physicians,insurance companies and other information as necessary to verify the information provided in this application although Boehringer Ingelheim Cares Foundation, Inc. is not obligated to verify any of the information contained in Section 1 above or confirm other medications that I am taking. I understand that the information used or disclosed may be subjected to re-disclosure and no longer protected by HIPAA. I understand that I may revoke this consent and withdraw from participation in the PAP at any time by mailing a letter to the PAP (Solutions Plus, address at top left). I understand that this form expires in one year or when my eligibility to the program expires. Specialty Pharmacy may receive financial remuneration from a third party (e.g., a pharmaceutical manufacturer) in connection with our communicating to you.

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

Don't forget to include ORIGINAL prescription(s) signed by prescribing physician Please see full prescribing information for Gilotrif®