PRESCRIPTION *Hope*

$15 Per Medication Per Month Prescription Hope Program

Revolutionary Prescription Coverage

- Prescription Hope's program offers access to more than 1,500 prescription medications from more than 80 pharmaceutical companies, to people with low to moderate income, including seniors on Medicare.
- Individuals have not been able to take advantage of this opportunity because of the complicated paperwork and administrative procedures required by the patient and his/her doctor.
- Qualified individuals, including seniors, are able to obtain brand name medications for a $15.00 per prescription, per month service fee.
- Qualifications include annual income level, insurance coverage, availability of prescription medication and other factors.

The Crisis

- Multiple prescription medications can cost hundreds of dollars per month.
- For example, a 90 day supply of:
  Plavix (75mg, 90-day supply) = $529.36
  Celebrex (200mg, 90-day supply) = $416.60
  Total = $945.96

Costs vary widely by retailer, these figures are from Drugstore.com.

The Solution

- Prescription Hope works directly with each pharmaceutical company's charitable assistance programs to obtain prescription medications.
- If qualified, each person will typically receive prescription medications in 90-day supplies.
- Participants can add new medications at any time, each for only $15.00 per prescription, per month.

Program Costs

- Brand name prescription medications for a $15.00 per prescription, per month service fee.
- There are no application fees, no other medication costs and no hidden costs.
- After that time, Prescription Hope manages the process of automatically refilling your prescriptions to maintain continual prescription medication coverage.

Qualifications

- Income level can be up to $30,000 per year as a single person and $50,000 per year for a couple.*
- May have health insurance. HMO participants qualify.
- Seniors on Medicare may qualify.
- You may have a discount prescription drug card and qualify.
- Do not participate in Medicaid.

*These are average figures; some pharmaceutical company's income guidelines may be higher.

Benefits

- No age limit.
- This is not a discount card. This is not an insurance product.
- We work with you and your doctor to assist you in receiving your medications.

Prescription Hope
1.877.296.HOPE (4673)

Learn More and Apply at
www.prescriptionhope.com

PRESCRIPTION Hope

PATIENT PRE-QUALIFYING APPLICATION

$15 Per Prescription Per Month Brand Name Medication Program

(PLEASE PRINT CLEARLY)

Name: ______________________ Address: ______________________

City: ____________ State: ______ Zip: ______ Phone :( ) ________ Fax :( ) ________

SSN: _____ - _____ - ______ DOB: ____/ _____ /_____ Marital Status: S☐ M☐ W☐ D☐

US Citizen: Yes ☐ No ☐ Gender: Male ☐ Female ☐ How Many People in Household: ______

* Are you on Medicare: Yes ☐ No☐ Medicare Part D: Yes ☐ No☐ Are You Disabled Yes ☐ No☐

Employment Status: Retired ☐ Unemployed ☐ Full-time ☐ Part-time ☐

Alternate Contact Name: ______________________ Alt Contact Phone: ( ) ______________

How did you hear about Prescription Hope? (please be specific) ______________________

Doctor's Names – only list doctors that prescribe the medications for you.

(Please print your doctors full mailing address)

Doctor 1: ______________________
Facility Name: ______________________
Address: ______________________
City: ______________________
State: ____________ Zip: ____________
Office Phone: ( ) ________ Fax:( ) ________

(Please print your doctors full mailing address)

Doctor 2: ______________________
Facility Name: ______________________
Address: ______________________
City: ______________________
State: ____________ Zip: ____________
Office Phone: ( ) ________ Fax:( ) ________

Please list only the medications that you need assistance with

Doctor 1 or 2	Medication Name	Strength	Frequency (ex: Take once daily)

Monthly Household Income (If married, include both husband and/or wife)

Gross Salary/Wages:	$	Unemployment:	$	Alimony:	$
SS Retirement:*	$	Pension/Retirement:	$	Other:	$
SS Disability:*	$	Interest/Annuity/IRA:	$	List Source of Other Income:	

* *If you are on Medicare please send a copy of your 2010 Social Security New Benefit Amount Statement with this application.*

(USE ADDITIONAL SHEET IF NECESSARY FOR THE DOCTORS AND/OR PRESCRIPTIONS)

Electronic Debit Information
Please choose either a checking account or a Visa or MasterCard for the monthly service fee

Electronic Check ☐ PLEASE ATTACH VOIDED CHECK :

☐ ☐ CREDIT CARD ACCOUNT NUMBER (ALL 16 DIGITS) Exp: Month Year

***We accept only Visa or MasterCard; this can be in the form of a debit card as long as it has a Visa or MasterCard logo or electronic check. Your account will not be charged until approximately 30 days from the time we receive your application. Within this time you will be notified in writing of the medication we are able to assist you with.**

**** If the payment section of the application is not complete we will be unable to process your application.**

Privacy Policy: We take our patients' privacy extremely serious. Customer information is used for order fulfillment only. Customer information, including all patient health information and personal information, will never be disclosed to any third party under any circumstances. All information given to Prescription Hope Inc. will be held in the strictest confidence.

I authorize Prescription Hope Inc., through its employees and/or agents, to act on my behalf to sign applications for patient assistance programs by giving Prescription Hope Inc. a limited power of attorney for this specific purpose only. I understand that this authorization can be revoked at any time by me by providing written notification of the revocation to Prescription Hope Inc. I authorize my doctor's office to discuss/release medical information to Prescription Hope Inc. and/or its agents relating to my application(s) for patient assistance program(s) that Prescription Hope Inc. is processing on my behalf. I understand that Prescription Hope Inc. does not ship, prescribe, purchase, sell, handle or dispense prescription medication of any kind in its efforts to process my application(s) for patient assistance program(s). Prescription Hope Inc. is a fee based service that assists patients in enrolling in each of the pharmaceutical company's patient assistance program(s). I also understand that it is each individual pharmaceutical company, not Prescription Hope Inc., who make the final decision as to whether I qualify for their assistance program(s). I understand that Prescription Hope Inc. reserves the right to rescind, revoke, or amend our services at any time. **Prescription Hope Inc. does not guarantee your approval for patient assistance programs. It is up to each applicable drug manufacturer to make the eligibility determination. Each drug manufacturer independently sets its own eligibility criteria and determines which products are included in their assistance program(s). Medications covered are subject to change at any time.**

By initialing I have read and understood the above paragraphs.

Please initial here __________ (We will be unable to process your application without your initials here)

Fees: Prescription Hope charges for the administrative service of managing, tracking and refilling prescription medications received with our assistance through pharmaceutical sponsored patient assistance programs with the goal to maintain continual prescription medication coverage. Our organization provides the administrative services to enroll in each pharmaceutical program. There are no other fees charged other than what is explained on this page. It takes approximately 4-6 weeks to start receiving your first 3 months supply of medications directly from the pharmaceutical companies; delivered either to your doctor's office or to your home. We will begin debiting your account approximately 30 days after the receipt of this application. We will not charge for medication we are unable to obtain for you. I understand that I will not receive a refund of any kind for the first three (3) months debits per prescription we process on your behalf unless the specific medication was denied by the pharmaceutical company.

Guarantee: If you receive no medication because you were determined to be ineligible for patient assistance program(s) by the applicable drug manufacturers and you have a letter of denial, we will gladly refund the monthly service fee(s) for the medication determined to be ineligible. All we need from you is a copy of the denial letter sent to you from the applicable drug manufacturer explaining why you are ineligible.

I authorize Prescription Hope Inc. and / or its agents to debit the account provided above for the $15 monthly service fee per prescription. I agree to pay any associated fees should my EFT (electronic fund transfer) be returned unpaid by my financial institution. I understand this agreement is for 12 months and will automatically be renewed. I may terminate this agreement at any time by providing a 30 day written notice. Upon termination I agree to be financially responsible for any outstanding balances.

This monthly transaction will appear on your billing statement as "PRESCRIPTION HOPE".

By initialing I have read and understood the above paragraphs.

Please initial here __________ (We will be unable to process your application without your initials here)

I meet the guidelines below:
I'm experiencing hardship in affording my medication and I currently don't have coverage that reimburses or pays for my prescription medications.
I affirm that the information provided on this application is complete and accurate.

NOTE: DO NOT DELAY TAKING REQUIRED PRESCRIPTION MEDICATION WHILE YOU WAIT FOR PRESCRIPTION HOPE INC. TO PROCESS YOUR APPLICATION AS THE APPROVAL PROCESS CAN TAKE APPROXIMATELY 4 TO 6 WEEKS. PRESCRIPTION HOPE IS NOT RESPONSIBLE FOR ANY ADVERSE HEALTH CONSEQUENCES THAT MAY RESULT DUE TO A DECISION TO DELAY TAKING REQUIRED PRESCRIPTION MEDICATION IN RELIANCE UPON OUR PROGRAM.

Signature:__________________________________ **Date:**__________________

Applicants Signature

Please complete, sign, and mail this entire application to the address below or you can fax to 1-877-298-1012.

Prescription Hope Inc.
P.O. Box 100
Westerville, Ohio 43086