PRESCRIPTION Hope

$15 Brand Name Medication Program

Revolutionary Prescription Coverage

- Prescription Hope's program offers access to more than 1,500 prescription medications from more than 180 pharmaceutical companies.
- 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 per prescription, per month service fee.

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, Inc. works directly with each pharmaceutical company's 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 per prescription, per month.

Program Costs

- Brand name prescription medications for a $15 per prescription, per month service fee.
- There is a yearly enrollment fee of only $15; no other medication costs and no hidden costs.

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.

* 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 directly with the patient, their doctor and the pharmaceutical manufacturer to assist in receiving ongoing medication.
- Prescription Hope, Inc. manages the process of automatically refilling your prescriptions to maintain continual prescription medication coverage.

Learn More and Apply at
www.prescriptionhope.com

Prescription Hope
1.877.296.HOPE (4673)

PRESCRIPTION Hope

PATIENT PRE-QUALIFYING APPLICATION

$15 Per Prescription Per Month Brand Name Medication Program

(ONE APPLICATION PER PERSON. PLEASE PRINT CLEARLY)

Name: ____________________ Address: ____________________

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

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

Email Address: ____________________

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)	(Please print your doctors full mailing address)
Doctor 1:	Doctor 2:
Facility Name:	Facility Name:
Address: Suite	Address: Suite
City:	City:
State: Zip:	State: Zip:
Office Phone: ( ) Fax:( )	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:	

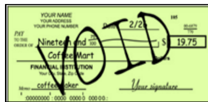
* *If you are on Medicare please send a copy of your 2011 Social Security New Benefit Amount Statement with this application.*

(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 :



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

Please choose Visa, MasterCard or electronic check. Your account will be charged 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 the application will not be processed.**

Fees: Prescription Hope, Inc. charges a $15 per medication per month administrative service fee. There is a non-refundable yearly enrollment fee of $15, this fee is charged at the time we receive this application. We will begin debiting the monthly prescription service fees approximately 30 days after the receipt of this application. Within this time you will be notified in writing of the medication we are able to assist you with. There are no other fees to the program or cost for the medications other than what is explained in the section of fees on this page.

It will take approximately 4-6 weeks to start receiving your first 90 day supply of medications. This is an average amount of time and is contingent on a prompt response to the information we request from you and your physician(s). The medication is shipped directly from the pharmaceutical companies; delivered either to your home or physician's office. I understand that I am not paying for the medication(s) through the Prescription Hope program; rather I am paying for the administrative service of ordering, managing, tracking and refilling of medications received with our assistance through pharmaceutical sponsored patient assistance programs.

I authorize Prescription Hope, Inc. and / or its agents to debit the account provided above for the monthly service fee per prescription and the yearly enrollment fee charged once per year on your annual renewal date. I agree to pay any associated fees should my EFT (electronic fund transfer) be returned unpaid by my financial institution. Due to the serviced based nature of the Prescription Hope program there are no refunds other than what is explained in our Guarantee below.

I understand this agreement is for 12 months and will automatically be renewed. I may terminate this agreement at any time by providing a letter of cancelation signed by the patient. Cancelations can take up to 30 days to process. 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)

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.

Service: 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 physician's office to discuss/release medical information to Prescription Hope, Inc. and/or its agents relating to my application(s) for patient assistance programs 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 programs. Prescription Hope, Inc. is a fee based service that assists patients in enrolling in each of the pharmaceutical company's patient assistance programs. The medications themselves are offered through patient assistance programs at no cost. 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 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 programs. 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)

Guarantee: If you receive no medication because you were determined to be ineligible for patient assistance programs 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 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, INC. IS NOT RESPONSIBLE FOR ANY ADVERSE HEALTH CONSEQUENCES THAT MAY RESULT DUE TO A DECISION TO DELAY TAKING YOUR REQUIRED PRESCRIPTION MEDICATION IN RELIANCE UPON OUR PROGRAM.

Signature: ____ **Date:** ______________________

Applicants Signature

Please complete, sign, and mail or fax this entire application to the address below:

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

Fax: 1-877-298-1012