Patient Assistance Program Application and Prescription

Reimbursement Navigator

orthogenrx.aspnprograms.com
P: (866) 556-2259 | **F:** (866) 377-2244
Email: Navigator@asembia.com

Patient Information

First Name:	Last Name:		
Address:	City:	State:	Zip:
Phone Number:	Gender: ☐ Male ☐ Female	Date of Birth:	
Is the above patient uninsured? ☐ Yes ☐ No	Insurance Provider: If a denial has already been received, please submit that information with this form		

Is the patient a resident of the fifty U.S. States, the District of Columbia, Puerto Rico, or the U.S. Virgin Islands? ☐ Yes ☐ No

Prescriber Information

First Name:	Last Name:	NPI:	
Office Address:	City:	State:	Zip:
Office Phone:	Office Fax:	Office Email:	

Patient Assistance Program Eligibility

- Patient must be 22 years of age or older and have a valid prescription.
- Patient must be a US citizen or legal resident in U.S. Territories.
- Patient's total household income must be at or below 300% of the Federal Poverty Level
- Patient must have no insurance, is underinsured and/or does not have a medical or pharmacy benefit to pay for the OrthogenRx Medication
- This request must be completed and accompanied by a copy of one of the following documents:
  - Previous year's federal tax return (form 1040 or 1040EZ)
  - Wage and tax statements (W-2 forms)
  - Two recent paycheck stubs
  - Social security, pension, or retirement statements (SSA-1099 or similar)
  - Patient will notify their insurance plan that they are receiving product outside their plan

By signing below, I hereby authorize my prescriber, pharmacy or other health care provider set forth above to disclose and transmit my Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, as amended) to Orthogenrx Pharmaceuticals ("Orthogenrx") and any third party engaged to support Orthogenrx in administering the Patient Assistance Program ("Program") for the purposes described herein. I understand that my PHI may include my name, address, income, prescription coverage, prescription for drug(s) or device(s), financial documents and insurance records, other information provided on this application form, and any information reasonably requested by Orthogenrx for the purposes of (i) determining my eligibility to participate in the Program, both initially and throughout my participation in the Program, (ii) shipping appropriate drug(s) and/or device(s) as prescribed by my licensed prescriber, and (iii) administering, evaluating, and improving the Program. I understand that signing this authorization does not guarantee that I will be accepted into the Program. : I will notify my insurance plan that i am receiving product outside my plan. I further understand that after my information is disclosed to Orthogenrx, it may no longer be protected under federal law and could be subject to re-disclosure. This authorization will expire one (1) year from the date of my signature below, as required by law, or upon execution of a new authorization pursuant to reapplication to the Program. I may revoke this authorization at any time by providing written notice to Orthogenrx at Orthogenrx Reimbursement Navigator, c/o ASPN Pharmacies, LLC., 290 West Mount Pleasant Ave, Building 2, 4th Floor, Suite 4210, Livingston, NJ 07039. My revocation will become effective on the date my written notice is received and processed by Orthogenrx. If I revoke my authorization, I understand this means I may no longer be able to receive assistance from the Program and the revocation may not apply to information disclosed in reliance on a valid authorization. I also understand that I may refuse to sign this authorization and that doing so will not affect my prescriber's treatment of me or my eligibility for insurance benefits. I also understand I have a right to receive and/or make a copy of this authorization. I attest, by signing below, that the information I am providing is truthful and accurate.

Patient Signature:	**Date:**

I understand and certify the above medication is intended for my patient's treatment, and no units of this product will be submitted for Medicare, Medicaid or any public or private third-party reimbursement, or returned for credit. I will not bill this Patient or any government program or commercial payer for the Patient Assistance Product, injecting the Patient Assistance Product, or other services necessary to the administration of the Patient Assistance Product. I understand eligibility under this program is subject to 'OrthogenRx Reimbursement Navigator Services' ("Program") approval and the patient's continuing compliance with all eligibility requirements, as set by OrthogenRx Inc. I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release medical and/or other patient information to Reimbursement. Services and its affiliates, agents, representatives, and service providers to use and disclose as necessary to enroll my patient. I authorize OrthogenRx, its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy. TriVisc is indicated for the treatment of pain in osteoarthritis (OA) of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and simple analgesics, e.g., acetaminophen. Do not administer to patients with known hypersensitivity (allergy) to sodium hyaluronate preparations. Do not inject TriVisc in the knees of patients with infections or skin diseases in the area of the injection site. Full prescribing information can be found in product labeling, at www.trivisc.com or by contacting customer service at 1-877-517-5445. I attest, by signing below, that the information I am providing is truthful and accurate.

TriVisc 3 injection hyaluronic acid regimen	☐ Unilateral Qty. 3 Syringes ☐ Bilateral Qty.6 Syringes	**Prescriber Signature:**	**Date:**

Distributed by:
OrthogenRx, ® Inc.
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