P.O. Box 5666
Louisville, Kentucky 40255-0666
Phone: 1-888-CARES-55 (1-888-227-3755)
Fax: 1-877-9-CARES-9 (1-877-922-7379)

Thank you for your interest in the Shire Cares Patient Assistance & Support Program. If you are having trouble affording your Shire medicines, this program may be right for you.

The type of assistance available varies based on the medicine that has been prescribed for you, your household income, and your insurance status. To receive prescription medicine assistance from Shire Cares, you and your doctor must complete and submit this application form in its entirety, and meet program eligibility requirements. We have included a checklist at the bottom of this page to guide you through completing and submitting your application.

If you have any questions, please call the program at 1-888-CARES-55 (1-888-227-3755). We are available to answer your calls Monday through Friday, from 8 AM to 8 PM Eastern Time, except for Holidays.

Please note: Submission of a complete application form does not guarantee enrollment in Shire Cares. Each application will be considered on a case-by-case basis. For your convenience, the general income guidelines for free assistance with your Shire medicines are included below.

Number of People in Your Household	Total Yearly Income
1 person	$62,450
2 people	$84,550
3 people	$106,650
4 people	$128,750
5 people	$150,850

APPLICATION CHECKLIST: *Please ensure all items on the list are completed and attached, or the application may be delayed*

DOCTOR
- ☐ Complete all fields in Section 1
- ☐ Fill out prescription information in Section 2
- ☐ Indicate medicine shipping preference in Section 2
- ☐ Sign and date the application form (no stamps; only original signatures accepted, must be dated to be a valid prescription)

PATIENT
- ☐ Fill out your personal information in Section 3
- ☐ Fill out your financial information in Section 4
- ☐ Attach proof(s) of income for your household
- ☐ If you have health insurance: fill out your insurance information in Section 5 and attach a copy of your insurance card
- ☐ Provide Test Claim as advised in Section 5 (Test Claim requirements provided to the right)
- ☐ Complete Section 6

PATIENT INSURANCE INFORMATION-SECTION 5
TEST CLAIM REQUIREMENTS
- Patient's first and last name
- Date of birth or patient's address
- Date of claim (within the past 30 days)
- Dispensed for a quantity of 30-days
- Must show the pharmacy name and address, if the pharmacy does a screen shot that does not show the pharmacy name or address, then the pharmacist can write those two items on the test claim but they have to sign and date it.

One of the following must be on the Test Claim to prove high co-pay
- Prior Authorization (PA) needed
- NDC not covered
- Not on formulary
- Co-pay amount reflects $50 or more

Please keep a copy of the application for your records

When you and your doctor have both completed the checklist above, send your form and attachments to us by fax or mail. Incomplete or incorrect information may delay the processing of your application, so please ensure that all information is provided correctly and that all signatures are obtained.

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PHYSICIAN COMPLETES THIS PAGE

SECTION 1: *PHYSICIAN INFORMATION*

Physician Name _____ *DEA# _____

National Provider ID _____

Facility Name _____ Tax ID _____

Address (No PO Box) _____

City _____ State _____ Zip _____

Phone _____ Ext _____ Secure Fax _____

Clinic Contact _____ Contact Title _____

***DEA Identification number required only if prescribing a controlled substance**

SECTION 2: *TO BE COMPLETED BY PHYSICIAN ONLY*

Patient Name _____ **Patient Date of Birth** _____

Allergies _____

Current Medications _____

Product *(Please select)*	**Dosage & Administration**	**Distribution**
☐ Vyvanse® (lisdexamfetamine dimesylate) Capsules CII	Pharmacy pick up physician must provide a prescription	☑ Pharmacy Card
☐ Vyvanse® (lisdexamfetamine dimesylate) Chewable Tablets CII	Pharmacy pick up physician must provide a prescription	☑ Pharmacy Card
☐ Mydayis® (mixed salts of a single-entity amphetamine product) Extended-Release Capsules CII	Pharmacy pick up physician must provide a prescription	☑ Pharmacy Card

Please Note: Coverage will not exceed the maximum daily dosage as indicated within Vyvanse and Mydayis prescribing information. Approval for up to 12 months.

***Product** (Please select and complete ship product to below)*	***Dosage***	***Administration***	***Distribution***	***Refills** (please select)*
☐ Carbatrol® (carbamazepine) Extended-Release Capsules	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ FOSRENOL® (lanthanum carbonate) Chewable Tablets	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ FOSRENOL®(lanthanum carbonate) Oral Powder	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ Lialda® (mesalamine) Delayed-Release Tablets	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ Motegrity™ (prucalopride) Tablets	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ PENTASA® (mesalamine) Controlled-Release Capsules	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ INTUNIV® (guanfacine) Extended-Release Tablets	☐ _____ mg	_____	☑ 90-day supply	❍1 ❍2 ❍3
☐ Xiidra® (lifitegrast ophthalmic solution) 5%		_____	☑ 90-day supply	❍1 ❍2 ❍3

Ship Product to ☐ Physician's Office ☐ Patient's Address *(If no selection is made, product will be shipped to Patient's Address)*

Physician / Prescriber Attestation

I represent that the information above is complete and accurate. I certify that this prescription is medically indicated for this patient and that I will be supervising this patient's treatments. I verify that to the best of my knowledge, this patient meets one of the following criteria: (1) has no health care insurance and is ineligible for public or private insurance reimbursement, and has insufficient financial resources to pay for the product prescribed, or (2) has health insurance with inadequate prescription coverage for the product prescribed, including all public programs, and the patient has insufficient financial resources to pay for the prescribed medication. I understand that Shire reserves the right to modify or terminate this program at any time. Furthermore, my signature certifies that these goods will not be resold nor offered for sale, trade, or barter and will not be returned for credit. I understand that Shire reserves the right to recall the product, if necessary.

Original Signature of Licensed Practitioner (no stamps accepted) _____ Date_____

shire cares
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PATIENT COMPLETES THIS PAGE

SECTION 3: *PATIENT PERSONAL INFORMATION*

Patient Name _____ Date of Birth _____

Phone _____ Gender ☐ Male ☐ Female

Social Security Number _____ US Citizen / Legal Resident? ☐ Yes ☐ No

Address (No PO Box) _____

City _____ State _____ Zip _____

Contact Name (if other than patient) _____ Relationship to Patient _____

May we share patient protected health information with your designated contact person? Yes☐ No ☐

Patient Protected Health Information consists of individually identifiable health information. This includes patient demographic information, or could possibly identify the patient relating to the provision of care; and/or relates to the past, present, or future physical or mental health/condition or payment concerning a patient.

SECTION 4: *PATIENT FINANCIAL INFORMATION*

Number of people in your household Adults = _____ **Children (18 and under within the same household) =** _____

Total combined adjusted net income for all people in your household, including all household dependents $ _____ Annually

You must provide proof of income to apply for this program. Please provide a copy of your most recent:

☐ Federal Tax Return **or** ☐ Pay Stubs (full month's worth of recent pay stubs) **or** ☐ Social Security Awards Letter

Have you lost your job in the past three (3) months? ☐ Yes ☐ No → If Yes, please attach proof of job termination or unemployment.

SECTION 5: *PATIENT INSURANCE INFORMATION*

Is your prescription drug copay over $50 and/or your total prescription drug deductible over $1,000? ☐ No → If Yes, please provide proof showing your prescription copay by submitting a test claim. **Test claim requirements can be located under the application checklist on the first page of this application.**

What type of insurance coverage do you have? (Check all that apply)

☐ None

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid

☐ State Pharmacy ☐ Employer ☐ Other _____ (Please fill in Name of Insurer)

For each policy you have, please attach a copy of both sides of your insurance card and fill in the following:

Primary Insurance		Secondary Insurance	
Insurance Plan		Insurance Plan	
Phone Number		Phone Number	
Name of Policy Holder		Name of Policy Holder	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Policy ID		Policy ID	
Group Number		Group Number	
Plan Type		Plan Type	

Has your insurance plan denied coverage for this medicine? ☐ Yes ☐ No → If Yes, proof of the denial is required. Please provide with this application.

Are you a Veteran? ☐ Yes ☐ No → If Yes, have you applied for VA benefits? ☐ Yes ☐ No

SECTION 6: PATIENT CERTIFICATION AND AUTHORIZATION

I hereby certify that I will notify Shire Cares if my financial circumstances or insurance coverage change within thirty (30) days of such change occurring. I certify that the information provided in this application is complete and accurate. I verify that the information provided in this application is complete and accurate. I further verify that I meet one of the following criteria: (1) I have no health care insurance and I am ineligible for public or private insurance reimbursement, and have insufficient financial resources to pay for the product prescribed, or (2) I have health insurance with inadequate prescription coverage for the product prescribed, including all public programs, and I have insufficient financial resources to pay for the prescribed medication. I understand that Shire Pharmaceuticals LLC reserves the right at any time and without notice to modify the application or modify or discontinue this program and related eligibility criteria.

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other health care provider to disclose to Shire Pharmaceuticals LLC and its agents all medical records and information, financial and insurance records and information as well as other identifying information, for the purpose of my participation in the Shire Cares Patient Assistance Program or for the purposes of gathering information on side effects or other safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC and its agents to contact my hospital, physician or other health care provider to obtain follow-up information on any such side effects or safety issues reported to Shire. I also authorize Shire Pharmaceuticals LLC and its agents to disclose all such records and information to any persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I authorize Shire Pharmaceuticals LLC to use my Social Security Number for identification purposes and record keeping only.

I authorize my healthcare providers, my dialysis clinic, and my health plan or insurers to give my medical and financial information to RxCrossroads, which administers the PAP on behalf of Shire Cares North America, the distributor of the medicines, and to Experian Search America, which assesses my income and ability to pay. I authorize RxCrossroads and Experian Search America to review my medical and financial information and to use it only to determine if I am eligible to participate in the PAP, to operate the PAP, or as otherwise required or permitted by law. I understand and agree that RxCrossroads and Experian Search America may contact me directly to verify the information I have submitted or to ask for additional information or documentation to process my application.

I understand that once RxCrossroads receives and processes my cancellation, I can no longer participate in the PAP and that RxCrossroads, Experian Search America and Shire Cares North America will not use my medical and financial information going forward.

Patient Name (Print) _____

Patient Signature _____ Date _____

→ If patient cannot sign or is <18 years of age, patient's representative must sign below

Patient Representative Name & Relationship to Patient (including description of authority to make medical decisions for patient)

_____

Patient Representative Signature _____ Date _____

****Please note, a valid signature requires both a signature and current date.****