PRASCO

Prasco.com RxOutreach.org

Patient Application

Questions?
We're here to help!

1-866-578-2444
or
Prasco@RxOutreach.org

Hours: Monday-Friday, 8AM - 6PM ET

Step 1: Eligibility Attestation

Select "Agree" or "Disagree" to each of the following patient eligibility criteria. All criteria must be met in order to qualify for this program.

Patient Eligibility will be verified using Experian Health Hub Services. For additional details of eligibility criteria, see Program Terms and Conditions. Patients with questions about the criteria should call 1-866-578-2444 or email Prasco@RxOutreach.org

Agree	Disagree	
○	○	Patient is human and able to acquire a valid prescription for the Prasco-labeled Fluticasone Propionate HFA Inhalation Aerosol (the "Product") from a licensed U.S. healthcare professional.
○	○	Patient must be at least four (4) years old. *For patients under the age of 18, a parent or legal guardian must complete the application process as the applicant on behalf of the patient. The parent or legal guardian will need to provide their name and date of birth to the Rx Outreach team during the enrollment process.*
○	○	Patient must live in the United States, District of Columbia, Puerto Rico, or U.S. Virgin Islands.
○	○	Patient's household income must be at or below 300% of the Federal Poverty Level for the location of patient's residence.
○	○	Patient cannot have any prescription drug coverage (including Medicare Part D, Medicaid, TRICARE, or commercial insurance) for Prasco-labeled Fluticasone Propionate HFA Inhalation Aerosol (the "Product").
○	○	Patient must not be enrolled in an "Alternate Funding Program" which, for the purpose of this Program, is defined as a program under the patient's insurance which requires the patient to apply for a manufacturer patient assistance program and be denied enrollment before the patient's insurance will cover the Product.
○	○	Patient must not be eligible for Puerto Rico's Government Health Plan Mi Salud or must have applied to the foregoing and been denied.
○	○	Rx Outreach must be able to verify patient's household income or lack thereof in accordance with the procedures described in the Program Terms and Conditions.

Step 2: Patient Information

FIRST NAME: _____ LAST NAME: _____

PATIENT DATE OF BIRTH (MM/DD/YYYY): ____ / ____ / _____

Is this patient under 18 years old? If YES, parent/guardian should complete below:

First & Last Name: _____ *Date of Birth:* ___ / ___ / _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ - _____ - _____ EMAIL: _____

Step 3: Product Details

Which strength of Prasco-labeled Product is the patient requesting?

- ◯ Fluticasone Propionate HFA Inhalation Aerosol 44 mcg
- ◯ Fluticasone Propionate HFA Inhalation Aerosol 110 mcg
- ◯ Fluticasone Propionate HFA Inhalation Aerosol 220 mcg
- ◯ Other: _____

Step 4: Referral Information

How did you hear about this program?

- ◯ Prescriber
- ◯ Friend/Family
- ◯ Prasco Website
- ◯ Prefer Not to Say
- ◯ Rx Outreach Website
- ◯ Social Media
- ◯ Search Engine

Step 5: Disclosures & Consent Statement

By submitting this application, I authorize Rx Outreach to administer the Program and to do the following:

1) Use any information that I provide in my application for the purpose of helping me receive the products under the Program or to administer the Program.

2) Receive and keep records of all prescriptions for the medications I receive under the Program, which will be used to administer the Program. While Prasco sponsors this Program, I understand patient data will not be disclosed to Prasco unless an audit is required for compliance purposes.

3) Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. This information will be used only to determine my eligibility for the Program and to administer the Program.

4) Contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

Terms and Conditions are continued on the back side of this sheet. Authorization and signature is required.

5) Authorize Rx Outreach to obtain a consumer report on me, including through Experian, to verify my income and ensure compliance with the stated eligibility criteria. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to determine if I am eligible to receive free medication in the Program.

6) Request additional documents and information at any time, even if I am already enrolled, so that they can determine if the information on this form is complete and true.

7) Disclose any information obtained from the sources listed above to third parties if required by law.

I understand that neither Prasco nor Rx Outreach charges a fee for participation in the Program. If I have used a third party who charges a fee for help with my enrollment form or refills of my medicine, this money is not paid to Prasco or Rx Outreach. I understand the authorizations provided by me in connection with the Program, including the above authorizations, will remain in effect for as long as I participate in the Program and for up to 7 years after my participation in the Program ends.

I also understand that I have the right to revoke this authorization at any time by calling 1-866-578-2444 or by mailing a signed written statement of my revocation to the Program. Such a revocation would end my eligibility to participate in the Program. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on my authorization.

I understand that once medical information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I understand that I am providing written instructions to Prasco, LLC and its vendor Rx Outreach under the Fair Credit Reporting Act authorizing Rx Outreach on behalf of Prasco to obtain information from my credit profile or other information from Experian Health or another third party credit bureau. I authorize Prasco, LLC and its vendor Rx Outreach to obtain such information solely for the purpose of determining financial qualification from the Program.

I certify that I have read, understand and will abide by the Program Terms and Conditions.

I certify that the information provided in this application is complete and accurate to the best of my knowledge.

I understand that Rx Outreach may contact me about this application, the Program, and my prescription via phone, text, email, and/or mail. Message and data rates may apply. You can opt out by calling 1-866-578-2444.

Unencrypted email and text are not guaranteed secure forms of communication and may pose a risk to the privacy of your health information. By agreeing to these terms, you accept this risk when using email or text to communicate with Rx Outreach. If you prefer a more secure method, please contact the Rx Outreach team to request alternative communication options.

For additional information about how Rx Outreach handles your information, please see Rx Outreach's privacy notice https://RxOutreach.org/privacy-policy/

Rx Outreach will not share any patient specific information, including any patient health information or financial information with Prasco. For information about how Prasco handles information see https://prasco.com/privacy-policy.html.

By submitting this application, I agree to the Program Terms and Conditions.

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____

DATE (MM/DD/YYYY): _____/_____/_____

Print, Fill Out Information, and Mail to:

Rx Outreach

P.O. Box 66536

St. Louis, MO 63166-6536

Processing time will vary based on delivery by the United States Postal Service.

Please wait at least two (2) weeks before contacting Rx Outreach for a status update.