Patient Assistance Program for Plaquenil®

Rx Outreach is fortunate to have a partnership with Concordia Pharmaceuticals to be able to offer the Plaquenil® Patient Assistance Program at no cost to those who are eligible.

There is a limited quantity available for this program, therefore it is restricted to people who are not able to use the generic for Plaquenil® (hydroxychloroquine). In order to qualify to receive Plaquenil®, you must:

- Enroll in the Rx Outreach program - complete form below, sign up online, or call a friendly Rx Outreach representative and enroll over the phone (must meet income guidelines)
- Submit a valid prescription for Plaquenil® 200mg
- Submit a letter from your doctor which states why the brand is necessary and that the generic is not effective
    - Prescriptions and letters may be faxed by the physician to 1-800-875-6591. (Please note, faxed prescriptions must come directly from the doctor's office)

Ask your doctor if this program would be good for you.

Don't delay as there are limited openings for this program. When the program is full, it will be closed to new customers. Existing customers enrolled in the Plaquenil® Patient Assistance Program will be able to continue to receive refills.

Just follow the easy steps below to get started:

1. Complete the first section on the Plaquenil® Enrollment Form on the next page.
2. Have your doctor complete the **Physician Section** on the Enrollment Form.
3. Mail or have the doctor fax the completed form to Rx Outreach.
4. Your medications will be sent directly to you.

We are excited about the opportunity to be able to offer this program to you at no cost.

If you have any questions, please contact Rx Outreach customer service at **1-877-318-9544**, Monday – Friday, 7:00 a.m. to 5:30 p.m. Central Time.

Enrollment Application

Plaquenil®
(hydroxychloroquine)

First Name	Last Name
Address	Date of Birth ______/______/________ (mm dd yyyy) Gender ________
Apt. #	Soc. Sec. # (optional) - -
City	Phone ( ) _______ - ____________
State Zip	Annual Income: $ ____________ # in Household ________

E-mail address:

Food/Medications you are allergic to: ____

Other Medications you are taking: ____

Shipping address if different from above:

Address ______________________________ City ____________________ State ______ Zip ________

I attest that the information provided in the application is complete and accurate. ________________________________**(Signature required)**

(If advocate/guardian signing on behalf of the patient – please denote relationship)

Patient Advocate/Guardian Contact: ______________________________ Phone: ( ) ______-________

Physician Section

Physician, please provide information below as to why this person cannot take the generic for Plaquenil® and requires the brand. (MUST BE COMPLETED TO BE ELIGIBLE):

STRENGTHS/DOSES AVAILABLE **Note: SHADED AREAS MUST BE COMPLETED**

NDC	Medication	Quantity	
24987-562-10	Plaquenil® 200mg		There is no cost to the patient for up to a 90-day supply, sponsored by Concordia Pharmaceuticals, Inc.
Directions:			______ **Refills**

NJ, NY & TN PRESCRIBERS: Please submit all prescriptions on official state security blanks. Do not use this form.

Physician Name: ____________________________________ DEA/ST Lic. # ________________ **(REQUIRED)**

Phone Number: (_____) ________-___________ Fax Number: (_____) ________-___________

________________________________ ____/____/_____ ____________________________

SUBSTITUTION PERMITTED (Physician Signature) mm dd yyyy Dispense as Written

Note: This form may be faxed to 1-800-875-6591 – Must be faxed from a doctor's office.

If Mailing: Send to:

Rx Outreach
P.O. Box 66536
St. Louis, MO 63166-6536

Event Code
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