Arestin® minocycline HCl 1 mg MICROSPHERES

PATIENT ELIGIBILITY FORM

Fax 855.630.9783 **Phone** 855.684.7481

Fax both forms together
All fields required for submission

ARESTIN COPAY ASSISTANCE PROGRAM

You may be eligible to save through the ARESTIN Copay Assistance Program.

Up to $1,500.00 in copay assistance.

Offer Restrictions and Eligibility Requirements below.

OFFER RESTRICTIONS AND ELIGIBILITY REQUIREMENTS

- This offer is only valid for patients with private commercial insurance, where ARESTIN® (minocycline HCl) Microspheres, 1 mg is a covered medication.
- This offer is not valid for any person eligible for reimbursement of prescriptions, in whole or in part, by any federal, state, or other governmental programs, including, but not limited to, Medicare (including Medicare Advantage and Part A, B, and D plans), Medicaid, TRICARE, Veterans Administration or Department of Defense health coverage, CHAMPUS, the Puerto Rico Government Health Insurance Plan or any other federal or state health care programs.
- You agree not to seek reimbursement for all or any part of the benefit received through this offer and are responsible for making any required reports of your use of this offer to any insurer or other third party who pays any part of the prescription filled.
- Offer good only in the United States through the ARESTIN Rx Access program. This offer is not valid where otherwise prohibited by law, taxed, or otherwise restricted.
- This offer is not valid with other offers. The coupon has no cash value. No cash back.
- This benefit can be used only for an ARESTIN prescription filled by Accredo Health specialty pharmacy and dispensed to the dental office on behalf of the patient as authorized below.
- You must be 18 years of age or older to redeem this offer for yourself or a minor. This offer cannot be redeemed at government-subsidized clinics.
- This offer is only valid on one prescription fill of ARESTIN.
- The maximum benefit available is $1,500 per prescription fill. You are responsible for all additional costs and expenses after the maximum benefit is reached.
- If you receive coverage through a health savings account (HSA) or similar arrangement, it is your responsibility to know how claims are processed and understand that amounts paid by the third party for your ARESTIN prescription may be deducted from your benefits limit automatically.
- This offer is not health insurance. This offer expires on December 31, 2017.
- Valeant Pharmaceuticals reserves the right to rescind, revoke, terminate, or amend this offer at any time, without notice.

By signing this ARESTIN Rx Access Patient Eligibility Form, you confirm that you understand and agree to comply with the above terms and conditions of this offer.

PATIENT

Patient name			
Patient date of birth (mm/dd/yyyy): / /			
Prescriber name			
Address	City	State	Zip

PATIENT SIGNATURE

By signing below, you are indicating that you meet the eligibility criteria and agree to the terms and conditions set forth above and Accredo Health Group has your consent to ship the medication directly to your prescriber's office. For questions call: 1-855-684-7481.

X ______________________________ Patient signature

______________________________ Date (mm/dd/yyyy)

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