



PATIENT SECTION (Patient must complete this section; Please PRINT legibly)		
NAME:	SOCIAL SECURITY #:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	PHONE #:	IS PATIENT A LEGAL U. S. RESIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>
DO YOU, THE PATIENT, HAVE ANY PRESCRIPTION (RX) COVERAGE WITH:		
Medicaid YES <input type="checkbox"/> NO <input type="checkbox"/> Medicare Part D YES <input type="checkbox"/> NO <input type="checkbox"/>		
Veteran's Administration YES <input type="checkbox"/> NO <input type="checkbox"/> State or local program (e.g., PACE programs) YES <input type="checkbox"/> NO <input type="checkbox"/>		
Private Insurance (including HMO/PPO) YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, you must provide proof of insurance company denial of coverage.		
IF YOU HAVE Rx INSURANCE, YOU MUST PROVIDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION: PHARMACY NAME and PHONE NUMBER, DOCUMENTATION OF ACTUAL OR POTENTIAL COST (i.e., OUT-OF-POCKET EXPENSES) FOR YOUR MEDICATIONS, INCLUDING VANCOCIN.		
TOTAL YEARLY HOUSEHOLD INCOME – INCLUDE ALL SOURCES E.G. SOCIAL SECURITY, PENSIONS, ETC. \$ _____		
PLEASE ATTACH FEDERAL TAX FORM(S) INDICATING INCOME		
NUMBER OF RESIDENTS IN THE PATIENT'S HOUSEHOLD IS (Check box) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/>		

I authorize ViroPharma Incorporated and their agents to use this information to assess my eligibility to participate in the ViroPharma Patient Assistance Program. In the event that I am eligible, I understand that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that this program may be changed or discontinued at any time. I certify that I do not have the ability to pay for my medication **and that I have no government or private insurance to help pay for my medication.** By signing below I verify that the information on this application, including financial information, is complete and accurate.

Original Signature of Patient

Date

LICENSED PRACTITIONER SECTION (PLEASE PRINT LEGIBLY; ILLEGIBLE FORMS WILL BE RETURNED FOR RE-SUBMISSION)		
NAME:	PROFESSIONAL DESIGNATION: (MD, DO, etc.)	
MAILING ADDRESS: (No P.O. Boxes)		
CITY:	STATE:	ZIP CODE:
SHIPPING ADDRESS: (If different from above; No P.O. Boxes)		
CITY:	STATE:	ZIP CODE:
OFFICE PHONE #:	OFFICE FAX #:	
DEA #:	<i>(If you do not have a DEA# please attach a copy of your current state license)</i>	
CONTACT PERSON IN OFFICE:	CONTACT PHONE #:	

I verify that the information is complete and accurate to the best of my knowledge. I understand that ViroPharma Incorporated will send the medication to my office for dispensing to my patient. ViroPharma reserves the right to request additional information if needed, and to change this program at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for a patient participating in the ViroPharma Patient Assistance Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government or third party insurer and will only provide such product for the patient listed on this application.

Original Signature of Licensed Practitioner **(no stamped signatures)**

Date