



Patient Assistance Application Form

Instructions:

Please fill out the application completely, be sure to print, sign and mail this form along with your prescription(s) to:

**Xubex® Pharmaceutical Services
Patient Services Group
PO Box 1244
Winter Park, FL 32790-1244**

You may call us, toll free at: 1-866-699-8239 or 407-478-2663. For faster service you may **FAX** your completed application and your prescription(s) to: **407-671-7960. Credit card orders only.**

Patient Information:

First Name:	Middle Initial:	Last Name:
Address:		Apt:
Address2:		Medicare ID: <input type="text"/>
City:	State:	Zip:
Date Of Birth:	Gender:	SS Number:
Phone:	ALT Phone: <input type="text"/>	Fax: <input type="text"/>
Email:	Income:	Number In Household:
Medication Currently Taking: <input type="text"/>		
Comment:		
Shipping Address if Different From Above:		
First Name:	Middle Initial:	Last Name:
Address:		Apt:
Address2:		Medicare ID: <input type="text"/>
City:	State:	Zip:

Drug Allergies (Please Check):

For Pharmacy Use Only	Allergic Conditions	X
32	Codeine	<input type="checkbox"/>
87	Sulfa	<input type="checkbox"/>
70	Penicillin	<input type="checkbox"/>
93	Tetracycline	<input type="checkbox"/>
00	No known allergies	<input type="checkbox"/>
00	Other (List)	<input type="checkbox"/>
00	Unknown	<input type="checkbox"/>

Health Conditions (Please Check):

For Pharmacy Use Only	Health Conditions	X
200	Diabetes	<input type="checkbox"/>
300	Hypertension	<input type="checkbox"/>
400	Heart Disease	<input type="checkbox"/>
500	Glaucoma	<input type="checkbox"/>
600	Stomach Disorders	<input type="checkbox"/>
700	Thyroid Disease	<input type="checkbox"/>
800	Arthritis	<input type="checkbox"/>
000	No known health conditions	<input type="checkbox"/>
000	Other (List)	<input type="checkbox"/>
00	Unknown	<input type="checkbox"/>

Payment Information

There is no enrollment fee or monthly charges and the medications are provided to you **FREE** of charge. An administrative fee is charged for EACH prescription and will be used to cover the costs of: Storing and handling the medications, processing fees, pharmacist and educational materials.

\$20.00 – 90 day supply (**\$30** for TierII Medication)

\$40.00 – 180 day supply (**\$60** for TierII Medication)

\$80.00 – 360 day supply (**\$120** for TierII Medication)

Please include appropriate administrative fee plus **\$3.85** for shipping and handling for each order.

Payment by Credit card:

Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Amex	Credit Card Number: _____	VCode: _____
	Name on Credit Card: _____	Exp. Date(mm/yy): _____

Cardholder Signature

X _____

I Authorize Xubex® Pharmaceutical Services to act as my agent in the State Of Florida to obtain and ship medication to the listed address. In addition I attest that the information provided in this application is complete and accurate. This authorization or a copy shall be valid for 12 months from the date of signature. I understand that Xubex® Pharmaceutical Services reserves the right to refuse to enroll me or dis-enroll me from the Patient Assistance Program based on any unintended use or abuse, or illegal distribution of any products in this program.

Authorization to Release and Disclose Medical Information By my signature I authorize Xubex Pharmaceutical Services and other companies Xubex Pharmaceutical Services uses to administer to do the following:

- 1) Xubex and its affiliates can use any information that I provide in my application for the Program for that purpose.
- 2) Manage and handle records of all prescriptions for the medications I receive under the Program.
- 3) Contact my doctor, healthcare provider, or pharmacist about my application for the Program, and disclose to them information contained in my application.

I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Program and for a period of 2 years after my participation in the Program ends.

Patient Signature

X _____

Date:

X _____

Xubex® Pharmaceutical Services reserves the right to add or delete medications available, change administrative fees, or discontinue Xubex® at any time. Xubex® Pharmaceutical Services does not accept returns of unused medication, and administrative fees are non-refundable once your prescription has shipped.

DEA # _____
LIC. # _____

Date _____

Patient

Name _____

DOB _____

Address _____ City _____ St. _____ Zip _____

Rx

Qty:

Sig:

(X) Dispense as Written, signed by provider

Refill _____ times

VOID if Not Signed by Provider