Xubex®
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http://www.xubex.com

Patient Assistance Program Application

Use this application form to register for Xubex's patient assistance program. Attach prescription(s) along with completed application and mail to the address above.

Patient Information

First Name		Mi		Last Name	
Address				Apt.	
City		State		Zip	
DOB		Gender		SSNumber	
Phone				Alt. Phone	
Email Address					

Insurance Information

Name		Bin#		PCN#	
ID#		Group#		Phone	

Medicare Information

Medicare ID	

Physician Information

Physician Name		State		Phone	
Fax				Alt. Phone	
Additional Comments					

list all medications you are currently taking including Over The Counter, Herbal or Supplements.

Medications and Supplements	

Drug or Food Allergies

☐ Codeine (32)	☐ Sulfa (87)	☐ Penicillin (70)	☐ Tetracycline (93)	☐ Other(00)	☐ Unknown (00)

Other Allergies	

Health Conditions

☐ Diabetes (200)	☐ Hypertension (300)	☐ Heart Disease (400)	☐ Glaucoma (500)	☐ Stomach Disorders (600)
☐ Thyroid Disease (700)	☐ Arthritis (800)	☐ No Known Health Condition (000)	☐ Other(000)	☐ Unknown (00)

Other Health Conditions	

Prescription Transfer Information

Please complete this section only if you are transferring your prescription from your pharmacy. Prescriptions must be written for 90 day supply.

New York State Residents: Our pharmacy staff can transfer one refill from your home pharmacy. If more than one refill is required, the prescribing clinician must authorize the transfer.

Pharmacy Name ______________________ Pharmacy Phone ☐☐☐☐☐☐☐☐☐☐

Medication Name	Rx Number

☐ I Authorize Pharmacists to substitute Generic Medications

Payment Information

◯ Check ◯ Credit Card Card ____________ Cardholder Name ____________

Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date ________ CVV ________

If paying by check or money order, please include appropriate fee for medications in your order plus shipping and handling per order.

Shipping Options:

Standard Shipping	$3.85
2-3 day Delivery Option	$25.00
Overnight Option	$45.00
Signature Required Option	$3.00

By my signature I authorize Xubex to administer the following:

1) Use any information that I provide in my application to enroll in the program.
2) Receive and keep records of all prescriptions for the medications I receive under the Program.
3) Contact my doctor, health care provider, or pharmacist about my application for the Program, and disclose to them information contained in my application.
4) Request information from my insurer, doctor, health care provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. By signing below, I also authorize my insurer, doctor, health care provider, or pharmacist to release information about my prescribed medications and medical condition that is requested.
5) Contact my insurer and other potential funding sources 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 Program application or information about my prescribed medications and medical condition that has been provided by my physician, health care provider, or pharmacist.
6) 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 3 years after my participation in the Program ends. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify Xubex of any change in my insurance eligibility.
7) By submitting this application, you confirm that you have read and agree to the Medicine Shoppe Xubex Pharmacy Privacy Policy posted at: http://www.xubex.com/privacypolicy.aspx

______________________________ ______________________
Applicant Signature Date

For Office Use Only