Reset Form

Sculptra® Patient Access Program
P.O. Box 430
Somerville, NJ 08876
Phone: (866) 310-7551
Fax: (866) 364-2016

VALEANT™ Aesthetics

Patient Section-The patient or his/her legal representative must complete this section.

Name _____ **SS# (last 4 digits)**_____

Mailing Address _____ **Date of Birth** _____

City _____ **State** _____ **Zip** _____ **Phone # (____)** _____

1. Is the patient a Legal U.S. resident? ☐ **Yes** ☐ **No**
2. Does the patient have prescription coverage for Sculptra® with any of the following:
   Government Insurance (Medicaid, Veteran's Administration, state or local programs, etc.) ☐ **Yes** ☐ **No**
   Medicare Part D ☐ **Yes** ☐ **No**
   Private Insurance (HMO, PPO, etc.) ☐ **Yes** ☐ **No**

If you answered yes in #2 to any of the coverage types, please submit FRONT AND BACK photocopies of your Prescription Drug Insurance Plan Card or Program Card along with this application

3. What is the patient's YEARLY INCOME including wages, social security, disability, etc.? **$_____YEARLY**
4. How many people, including the patient, live in the household? ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6+**

I verify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for this medication. I authorize Valeant Pharmaceuticals North America LLC and its agents to use my personal identifying information for the purpose of my participating in the Valeant Pharmaceuticals North America LLC Programs. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I understand that Valeant Pharmaceuticals North America LLC reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the Valeant Pharmaceuticals North America LLC Programs. Valeant Pharmaceuticals North America LLC is authorized to use my Social Security number for identification purposes and record keeping only.

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

Practitioner Section- The licensed practitioner must complete this section

NAME: **PROFESSIONAL DESIGNATION: (MD, DO, ETC.):**

OFFICE ADDRESS: (No P.O. Box)

CITY: **STATE:** **ZIP CODE:**

STATE LICENSE NUMBER: **SCULPTRA FACILITY NUMBER:**

OFFICE CONTACT PERSON: **OFFICE PHONE #:** **OFFICE FAX #:**

Prescription Information Section – The prescribing practitioner must complete this section

Sculptra® Number of Kits (2 vials per kit) for above named Patient: ☐ **1 Kit** ☐ **2 Kits**

Last Treatment Date : __/__/__

The use of the product for this patient is consistent with the following FDA-approved indication for Sculptra®: ***Sculptra® is intended for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.*** **YES** ☐ **NO** ☐

I verify that the information contained in this application is complete and accurate to the best of my knowledge. To the best of my knowledge, this patient has no prescription insurance coverage for the requested medication, including Medicaid or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I have read, understand and agree to all of the above. I attest that I am not on the HHS/OIG list of Excluded Individuals. I understand that Valeant Pharmaceuticals North America LLC reserves the right to modify or terminate this program at any time. My signature certifies that goods received from Valeant Pharmaceuticals North America LLC are for the use of the above patient only. These goods will not be sold nor offered for sales, trade or barter and will not be returned for credit. I understand that Valeant Pharmaceuticals North America LLC reserves the right to recall the product when necessary.

_____ _____
LICENSED PRATITIONER SIGNATURE (NO SIGNATURE STAMPS) DATE

Please note: Valeant Pharmaceuticals North America LLC will make every effort to grant aid for eligible patients. This program is limited to available resources and may be revised or discontinued at any time.