Alcon®

FAX to 817-568-7000

U.S. Patient Assistance Program (For U.S. licensed doctors only)

DOCTOR'S Name		State License Number:
Doctor's Address		
City	State	Zip
Phone	Fax	

Rx products must ship to the doctor to dispense to patient.

Ship To Attention:

To the best of my knowledge based on information available to me, this patient has no prescription insurance coverage for the requested medication, including Medicare, Medicaid or other public programs, and/or the patient has insufficient financial resources to pay for the prescribed therapy. My signature certifies that goods I receive from Alcon's assistance program are solely for use of the patient identified below. No attempt will be made to apply for reimbursement for any of the products provided from any public or private third party payor on behalf of a qualifying patient under this program. These goods will not be resold nor offered for sale, sample, trade, barter or used for any other purpose.

DOCTOR'S original signature	Date

PATIENT'S Name (please print)	Birth date: MM/DD/YYYY	Social Security Number

I verify information provided in this request is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for the requested medication or am unable to utilize such coverage. I understand I am expected to seek any available state or government assistance before applying to the Alcon Patient Assistance Program. No attempt will be made to apply for reimbursement for any of the products provided through Alcon's Patient Assistance Program from any public or private third party payor. I understand Alcon 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 authorize use of information on this application to process my request and authorize use of my Social Security Number only for identification purposes and record keeping.

PATIENT'S Signature	Date

GLAUCOMA Medications

(6-month supply will be provided to doctor to dispense to patient)

	PROSTAGLANDIN			ALPHA ADRENERGIC AGONISTS	
	TRAVATAN® .004%	6 ea 2.5ml btl		**IOPIDINE®** 0.5%	4 ea 10ml btl
	TOPICAL CAI (Carbonic Anhydrase Inhibitor)			Brimonidine Tartrate 0.2%	4 ea 15ml btl
	AZOPT® 1%	4 ea 15ml btl			
	BETA BLOCKERS			MIOTICS	
	BETOPTIC S® .25%	4 ea 15ml btl		**ISOPTO®** Carpine 1%	12 ea 15ml btl
	Carteolol HCL 1%	4 ea 10ml btl		**ISOPTO®** Carpine 2%	12 ea 15ml btl
	Levobunolol HCL .5%	4 ea 15ml btl		**ISOPTO®** Carpine 4%	12 ea 15ml btl
	Metipranolol Sol .3%	4 ea 10ml btl		**ISOPTO®** Carbachol 1.5%	6 ea 30ml btl
	Timolol Maleate Gel .25%	4 ea 5ml btl		**ISOPTO®** Carbachol 3%	12 ea 15ml btl
	Timolol Maleate Gel .5%	4 ea 5ml btl			
	Timolol Maleate Sol .25%	4 ea 15ml btl		**PILOPINE HS®** Gel 4%	4 ea 4g tube
	Timolol Maleate Sol .5%	4 ea 15ml btl			

PHARMACEUTICALS ‡			**OTC PRODUCTS ‡** (Maximum 6-month supply per year)	
	CILOXAN® Solution	5ml btl	**BION® TEARS** Eye Drops	bx
	CILOXAN® Ointment	3.5g tube	**SYSTANE®** Eye Drops	btl
	CIPRO®* HC Otic	10ml btl	**SYSTANE®** Preservative Free Drops	bx
	CIPRODEX®* Suspension	7.5ml btl	**TEARS NATURALE®** Forte Drops	btl
	ECONOPRED® PLUS Suspension	10ml btl	**TEARS NATURALE FREE®** Drops	bx
	FLAREX® Suspension	5ml btl	**TEARS NATURALE®** PM Eye Ointment	tube
	MAXITROL® Suspension	5ml btl	**UNISOL®** 4 Saline Solution	btl
	TOBRADEX® Suspension	10ml btl	**Only OTC products may ship to patient.** Please provide:	
	TOBRADEX® Ointment	3.5g tube	Patient's Name	
	VEXOL®** Suspension	10ml btl	Address	
	VIGAMOX™*** Solution	3ml btl	City	
			State / Zip	

‡Explain patient's medical condition and medication dosage:

‡Long-term condition ♦ short-term condition ♦

‡If short-term, expected duration of treatment:

If you have questions, call 1-800-222-8103, option 2. Please allow 3 weeks for product delivery.

*CIPRO and CIPRODEX are registered trademarks of Bayer AG. Licensed by Bayer AG.
**VEXOL is a trademark of N.V. Organon. ***VIGAMOX™ is licensed to Alcon, Inc. by Bayer AG.

Alcon Cares™

Feb 2005

800-222-8103, option 2
FAX 817-568-7000

U.S. Patient Assistance Program

Who qualifies?

Any private patient of a U.S. licensed doctor who, in the judgment of the doctor, cannot afford their medication and has no prescription insurance coverage, and does not qualify for local, state or federal prescription programs.

Income guidelines: (in general, 200% of U.S. Poverty Guidelines)

Annual income for one person is less than $18,000; family of two is less than $25,000; family of four is less than $36,000.

How long is the medication provided?

- **Glaucoma medications** will be provided for the patient through a U.S. licensed doctor for as long as the doctor deems it a medical and financial necessity.
- **Prescription Pharmaceuticals** other than glaucoma medications will be provided for the length of the treatment plan determined by the doctor.
- **Over-the-counter products** recommended by the doctor for chronic eye conditions will be provided for a maximum of six-month supply per year.

How does a doctor apply for assistance for their patient?

- Complete all appropriate sections of the application.
- Incomplete or illegible applications will not be honored.
- **Fax** completed requests to **817-568-7000**.

NOTE:

- Make copies of the application for future requests.
- Re-orders require a newly completed application.
- The doctor participating in this program agrees that the medication will be dispensed free of charge and only to the patient for whom it has been requested.
- This program and guidelines are subject to change without notice.
- Power of Attorney or witness/signature by physician office personnel is permissible when patient is physically unable to sign the application.

If you have questions, please call 800-222-8103, option 2, for assistance.