GUIDELINES FOR THE ELOQUST HEALTHCARE, INC
PATIENT ASSISTANCE PROGRAM

Patient applications are evaluated on a case-by-case basis by Eloquest Healthcare, Inc. ("Eloquest") a subsidiary of Ferndale Pharma Group Inc. ("Ferndale"). In general, participation is limited to individuals who: (1) have an income below the U.S. Poverty Level, adjusted for household size; and (2) lack access to insurance coverage or public programs covering the pertinent medication. Patients approved into the Patient Assistance Program should receive shipment of over the counter product within 2-3 weeks. They will not receive an acceptance letter. However, patients and /or their physicians will receive a denial letter if an application is denied.

If approved, the product is sent to the patients home. With the shipment of the product the patient will receive instructions on how to request the next supply of product. It is the patient's responsibility to contact our office when you require the next refill. After the 6th refill should the patient still require the product, re-application is required.

Product distributed through the Patient Assistance Program is free of charge to all eligible patients. Eloquest is not associated with any individuals or organizations that may charge patients a fee (s) to assist in completing applications for our program. These organizations or individuals are acting independently and do not have Eloquest's consent.

This program offers temporary assistance to patients who meet the following requirements:

- The patient has no pharmaceutical insurance coverage.
- The patient cannot afford to pay for the product.
- The physician has determined that an Eloquest product may be appropriate for treating the patient.
- You live in the United States

In reference to the above qualifications you must have exhausted all other insurance options for coverage. Some examples of other insurance coverage include:

- Private insurance, HMO's, Medicaid, Medicare, state pharmacy assistance programs, Veterans assistance, or any other social service agency.

Note-Patients who meet the above qualifications will generally be eligible for the program. However, Eloquest reserves the right to accept or deny any application or to change or discontinue this program at any time without notice

Other Important Information:

For Patients: Please discuss the risks and benefits of all products with your doctor and take only as directed by your doctor.

For Healthcare Professionals: Before recommending the use of medical products, please read the indicated uses.

Fax completed application and all applicable documentation to 248-548-0279

PATIENT ASSISTANCE PROGRAM APPLICATION

SECTION 1 ***THIS SECTION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN***

Patient Name:						
Address:						
City:		State:		Zipcode:		
Phone:						
Social Security #:				Date of Birth:		
U.S. Resident:	YES ☐ NO ☐	Number of persons (including self) DEPENDENT upon primary income within family				

Supporting Documentation Required-Must send or fax a copy of Social Security/Disability Statement OR W2 OR Income Tax Statement for the year Gross Monthly Household Income of Applicant and Dependents.		**Non-Reimbursed Medical Expenses Paid out Monthly:**	
Salary/Wages/Dividends	$	Physician	$
Social Security	$	Lab Expenses	$
Social Security Supplemental Income	$	Hospital	$
Disability	$	Dental	$
Unemployment Compensation	$	Vision	$
Pension/Annuity	$	Other:	$
Alimony/Child Support	$		
Other:	$		
Total Month:	**$**	**Total Month:**	**$**

PLEASE PROVIDE INFORMATION REGARDING EACH OF THE FOLLOWING SOURCES OF FUNDING

	MEDICAL COVERAGE	**PRESCRIPTION DRUG COVERAGE**	**ELIGIBILITY STATUS: (E)- ELIGIBLE, (I)- INELIGIBLE, (P) PENDING**	**DATE APPLIED**	**IF NOT ELIGIBLE, PLEASE PROVIDE EXPLANATION**
Medicare	☐Y ☐N	☐Y ☐N			
Medicaid	☐Y ☐N	☐Y ☐N			
Private Insurance	☐Y ☐N	☐Y ☐N			
Prescription Insurance	☐Y ☐N	☐Y ☐N			
Employer Insurance	☐Y ☐N	☐Y ☐N			
HMO/PPO	☐Y ☐N	☐Y ☐N			
State Medical Aid	☐Y ☐N	☐Y ☐N			
Veterans Assistance	☐Y ☐N	☐Y ☐N			
Other:	☐Y ☐N	☐Y ☐N			

OVER THE COUNTER MEDICATIONS ONLY
Please indicate where you would like product sent:

Patients Name:					
Address					
City:		State:		Zip Code:	

INFORMATION TO BE COMPLETED BY THE PHYSICIAN IN ORDER TO PROCESS REQUEST
Valid for Eloquest Healthcare Products Only

Date:		Diagnosis:	
Product Needed: **(please indicate the name and size (ex. ml, oz)**			
Quantity:		Refill Times	1○2○3○4○
Physician Name:	MD/DO	DEA#:	
Physician Address:			
City	ST	Zip Code:	
Phone:	Fax:		
Physician Signature:			

Patient's Authorization and Acknowledgement

I affirm that the above information is correct and complete to the best of my knowledge. I authorize my physician to provide the above information to Eloquest and to any third party retained by Eloquest to assist in administering its Patient Assistance Program. I also authorize Eloquest and any third party retained by Eloquest to contact my physician for any additional information required in connection with my application or my participation in the program and I authorize my physician to provide that information. I understand that this is an application only and that Eloquest may decide in its sole judgment whether to grant this application or , if granted, to discontinue my participation in the program at any time. I also understand that my physician, and not Eloquest, is solely responsible for selecting the product described in this Application. Finally, I understand that Eloquest is not a health care provider and will not provide health care advice. This authorization shall continue in effect as long as I am a participant in the program. I understand that Eloquest will not use or disclose my information contained in this Application without my written permission except: (1) to evaluate my Application; (2) to operate and administer the Patient Assistance Program; (3) when required by law; (4) to your physician; (5) for law enforcement, regulatory and public health purposes; or (6) if all identifying information has been removed.

Patient/Applicants Signature:_____ Date: _____

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