Patient Assistance Program

The IBSA Patient Assistance provides medication at no cost to eligible patients. Eligible patients are non-Medicare eligible U.S. residents who have no prescription insurance coverage and whose household income falls at or below 200% of the U.S. Federal Poverty Level:

2020 Program Annual FPL Guidelines			
Family Size	**200% - 48 States**	**200% - Alaska**	**200% - Hawaii**
1	$ 25,520	$ 31,900	$ 29,360
2	$ 34,480	$ 43,100	$ 39,660
3	$ 43,440	$ 54,300	$ 49,960
4	$ 52,400	$ 65,500	$ 60,260
5	$ 61,360	$ 76,700	$ 70,560
6	$ 70,320	$ 87,900	$ 80,860
7	$ 79,280	$ 99,100	$ 91,160
8	$ 88,240	$ 110,300	$ 101,460
8+	+ $4,480/add'l person	+ $5,600/add'l person	+ $5,150/add'l person

Medications Currently Available on the IBSA Patient Assistance Program

- Tirosint® (Levothyroxine Sodium) – Not available to new patients
- Tirosint-Sol® (Levothyroxine Sodium Oral Solution)

Checklist for submitting an application:

- Ensure all sections of the application are completed.
- Please make copies of everything you send as no documents will be returned.
- Income is based on the household's annual adjusted gross income. Attach a copy of the most recent Federal Tax Return for all in the household. If the patient does not file taxes, please include a letter, signed by the patient stating this fact, along with other supporting documentation of income, including 1099, W2, disability/pension statement or pay stubs from two consecutive pay periods.
- Patient's signature and date are required on the application.
- Prescriber's signature and date are required on the application as this application is also the prescription. Stamps are NOT acceptable.
- Either fax the completed application and documentation to 1-833-340-7196 or mail it to:

IBSA Patient Assistance Program
P.O. Box 1229
Southampton, PA 18966

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If the patient is eligible for assistance, a 3 month's supply of medication will be shipped to the patient's home address.

Please contact the IBSA Patient Assistance Program with any questions or for additional assistance. We can be reached at 1-833-838-3247, Monday-Friday 9am-5pm EST.

Please fax to 1-833-340-7196
Phone: 1-833-838-3247

To qualify the patient must:

- Have no prescription insurance coverage
- Be a US resident
- Have a household income below 200% of the US Federal Poverty Level

PATIENT INFORMATION

Patient Name:			
Patient Address:			
City:		State:	Zip:
Patient Phone #:	Date of Birth:	/ /	Gender:
Last Four Digits of Social Security #:	Drug Allergies:		
Number of Individuals in the patient's household:			
Annual income of patient's household:			
Do you have any government or private prescription insurance coverage?	☐ YES	☐ NO	
Are you U.S. Resident?	☐ YES	☐ NO	

HEALTH INFORMATION

List any known allergies
List any known health conditions
List all current medications

AUTHORIZATION FOR PAP PARTICIPATION AND DISCLOSURE OF PATIENT INFORMATION: I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the IBSA Patient Assistance Program ("PAP") as determined by IBSA Pharma Inc. ("IBSA") or third parties contracted by IBSA. I agree that IBSA does not have any obligation to provide PAP services to me and I waive any and all liability of IBSA and its third party affiliates in the provision of PAP services. I understand that by completing this form, I am not guaranteed eligibility to receive medication at no cost from the PAP. In the event I am eligible for the PAP, I acknowledge that this assistance is temporary and may be asked to reapply at designated intervals as determined by IBSA. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP services will no longer be provided. I agree that I will not seek reimbursement for the requested medication from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes.

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the IBSA Patient Assistance Program, IBSA Pharma B.V., its affiliates, or contracted third parties for the following purposes: (i) to determine eligibility for the IBSA PAP, (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, and (iii) to administer and maintain the high quality of the PAP. I understand that once the PAP receives my health information, it may communicate with my health care providers and insurers to determine PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the PAP (should I qualify I understand that I may cancel this authorization at any time by writing to the IBSA Patient Assistance Program as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the PAP receives and processes my cancellation request, the PAP will not use my health information going forward. I understand that cancelling the Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 10 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the IBSA PAP and will no longer be protected by the Health Insurance and Portability Act.

Patient Authorization:	Date:

IBSA Patient Assistance Program Application

Please fax to 1-833-340-7196
Phone: 1-833-838-3247

Patient Name: Date of Birth:

PRESCRIBER INFORMATION			
Prescriber Name:			
Prescriber Address:			
City:		State:	Zip:
Office Phone #:	Office Fax #:		
Office Contact Name:			
State License #:	State where Licensed:	NPI#:	

PRESCRIPTION INFORMATION	DRUG/STRENGTH	INSTRUCTIONS	QTY	REFILLS

I certify that the information provided in this application is complete and accurate to the best of my knowledge, that the product ordered hereunder is medically indicated for this patient, and that I will be supervising the patient's treatment. I understand and certify that all units of any product that may be shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party (including, but not limited to, Medicare and any other governmental programs) shall be charged for such product. Additionally, no units of this product will be submitted for Medicare, Medicaid or any public or private third party reimbursement, or returned for credit. I understand eligibility under this program is subject to the IBSA Patient Assistance Program's ("PAP") approval and the patient's continuing compliance with all eligibility requirements, as set by IBSA Pharma Inc. ("IBSA"). I agree to allow the PAP or its authorized agent(s) to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the program and the patient's receipt of any product(s) provided to him or her through the program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-names patient.

PRESCRIBER SIGNATURE: _____ **DATE:** _____