Reset Fields

Romark Laboratories, L.C.

Romark Patient Assistance Program for Alinia®
3000 Bayport Drive, Suite 200
Tampa, FL 33607
Phone (813) 282-8544 Fax: (813) 282-1162
romarkpap@romark.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

Address (No P.O. Box): _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Sex: O M O F Date of Birth: _____ Phone: _____ Fax: _____

Household Income –Monthly (Income must include all in household): _____

Source of Income: _____ # in household: _____

Does the patient have any form of third party prescription drug coverage (partial or full) for the product requested?

Medicare O Yes O No Private insurance/HMO O Yes O No

Medicaid O Yes O No Other state/governmental program O Yes O No

Has the patient applied for financial assistance (Medicaid, ADAP, SS, etc.)? O Yes O No

If *yes*, has the patient been denied assistance: ☐ Yes ☐ No ☐ Pending ☐ Waitlisted ☐ QMB **(If yes, provide copy of denial QMB statement.)**

Patient Consent for Use and Disclosure of Information

I request and authorize the physician named below to release to Romark Laboratories, L.C., or third parties contracted by Romark Laboratories, L.C. in connection with the Romark Patient Assistance Program (collectively "Romark"), all information regarding my health and treatment, or that of the above patient for whom I am the legally authorized representative, pertaining to the requested medication named below. This authorization shall be valid for one year from the date it is signed. Except to the extent that this authorization has been relied upon by Romark and the physician named above, I may revoke this authorization by writing to them. I understand that information provided to Romark pursuant to this authorization may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) and may, therefore, be redisclosed. Romark will use and disclose such information to assist with the assessment of my eligibility for and enrollment in the Romark Patient Assistance Program, to account for my withdrawal if I decide to stop participating in this program, and as required by law. I understand that this authorization is not a condition for health care treatment and does not guarantee eligibility into or no cost medication for the Romark Patient Assistance Program.

In the event that I am eligible for the Romark Patient Assistance Program, I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that this program may be changed or discontinued at any time. I attest that the information I have provided is correct and complete. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer.

I also authorize Romark to use the information I have given for internal review and analysis and to provide me with helpful information.

_____ _____

Patient or Legally Authorized Representative's Signature Date

PHYSICIAN INFORMATION

Patient Number: _____ **(please assign a unique non-SS number for your patient)**

Physician's Name: _____ Professional Designation: _____

Office/Building Name: _____ Address (No P.O. Box): _____

City: _____ State: _____ Zip: _____

State License #: _____ **(A copy of the State License must accompany this application)**

Office Contact: _____

Office Phone #: _____ Ext: _____ Fax: _____

PRESCRIPTION INFORMATION

Check one of the following options:

☐ One (1) **60ml bottle, Alinia® (nitazoxanide) Suspension, 100mg/5ml** (67546-212-21PAP)

☐ One (1) tray of **10 total, Alinia® (nitazoxanide) Tablets, 500mg** (67546-111-37PAP)

☐ One (1**) 30 count bottle, Alinia® (nitazoxanide) Tablets, 500mg** (67546-111-12PAP)

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that Romark Laboratories, L.C. will send the medication to my office for dispensing to my patient. Romark Laboratories, L.C. reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for a patient participating in the Romark Patient Assistance Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer.

_____ _____ _____

Physician's Signature (STAMPS NOT ACCEPTED) **Specialty** **Date**