



UNINSURED PATIENT PROGRAM  
 PO BOX 520582 • LONGWOOD, FL 32750  
 PHONE: 888 • 417 • 7153 FAX : 888 • 212 • 7517  
 www.nitromed.com

**STEP ONE - Patient Completes**

Application Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PATIENT INFORMATION**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Gender:  Male  Female  
 Telephone \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Marital Status:  S  M  D  W  
 Social Security Number \_\_\_\_\_ Are you a U.S. resident?  Yes  No Are you a Veteran?  Yes  No  
 Number of Persons in Household \_\_\_\_\_ Gross Annual Household Income \$ \_\_\_\_\_  
 Annual Non-Reimbursed Medical Expenses \$ \_\_\_\_\_  
 Does the patient have any prescription coverage, including Medicare Part D?  Yes  No If so, please indicate: \_\_\_\_\_  
 Does the patient have a deductible for this medication?  Yes  No If so, please indicate: \_\_\_\_\_

I authorize NitroMed and its agents to use the information provided by me and my physician to assess my eligibility for participation in the NitroMed Cares™ Program. I understand that this assistance is temporary and that I will be asked to recertify my eligibility twice a year. I also understand that this program may be changed or discontinued at any time without notice. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third-party payer. I attest that the information I have provided is correct and I understand that all information will be treated confidentially.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**STEP TWO - Physician Completes**

**PHYSICIAN INFORMATION**

DEA Number \_\_\_\_\_ State License Number \_\_\_\_\_ Exp Date \_\_\_\_\_  
 Physician First Name \_\_\_\_\_ MI \_\_\_\_\_ Physician Last Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Office Contact \_\_\_\_\_  
 Does the patient have any allergies?  Yes  No If so, please indicate: \_\_\_\_\_

Please indicate prescription information: \_\_\_\_\_ Medication Ships to Physician's Office

I attest that the information provided is accurate to the best of my knowledge. I understand that, if approved, NitroMed will send the product directly to my office for the duration of the patient's enrollment in the program. NitroMed 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 NitroMed Cares Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third-party payer.

Physician Signature : \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PROGRAM INFORMATION**

**NITROMED CARES™ UNINSURED PATIENT PROGRAM**

No cost to patient ■ 90-day supply ■ Medication delivered to physician quarterly

NitroMed and its agents limit the collection and use of information contained on this form to that which is necessary to administer the NitroMed Cares™ Program. NitroMed and its agents will use this information only in accordance with the principles set out in the Privacy Policy and will not sell, trade or otherwise disclose any personally identifiable patient or physician information unless required to do so by law.

**When completed, fax to: 888-212-7517**



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