Pertzye®
(pancrelipase)
Delayed-Release Capsules

Assistance Program℠

This program is available for patients with financial difficulties. Physicians apply for this program on behalf of their patients. Eligibility is determined on a case-by-case basis through a formal review process at Digestive Care, Inc. Upon approval, a *FREE* three month supply of Pertzye® will be sent to the requesting physician for distribution to their patient. If another supply is needed, the physician is to submit another enrollment form.

Eligibility: Available to patients with commercial prescription insurance coverage for Pertzye®. Co-pay and deductible assistance is not available to patients receiving reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs) or where prohibited by law. Offer subject to change or discontinuance without notice. **This is not health insurance.**

To apply for this program, complete the enrollment form on the reverse side.

1120 Win Drive
Bethlehem, PA 18017-7059
Voice: 1-877-882-5950
Fax: 610-882-0349
www.pertzye.com

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Pertzye® (pancrelipase) Delayed-Release Capsules

Assistance Program℠
Enrollment Form

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Date of Request: _ _ - _ _ - _ _ _ _
Month Day Year

Fax this Enrollment Form to Digestive Care, Inc. at: **Fax 610-882-0349**

Physician Information:

Physician Name: Specialty:

Center Name: Phone:

Center Address: Fax:

City: State: Zip:

Physician Email:

Product Requested: ☐ Pertzye® 4,000 ☐ Pertzye® 8,000 ☐ Pertzye® 16,000 ☐ Pertzye® 24,000

Caps per Day: Caps per Meal: Caps per Snack:

Sig:

Physician Signature: DEA #

Patient Information:

Patient Name:

Date of Birth: - - Patient's Age: Weight: Height:

Insurance Information:

Reason for Request:

Patients participating in Medicare, Medicaid or any other State or Federal Subsidized Pharmacy Benefit Program are not eligible for this program.

Consent and Authorization Agreement

I hereby authorize Digestive Care, Inc. (DCI) to enroll the above-named patient in the Pertzye® Assistance Program℠. I understand the enrollment in the Pertzye® Assistance Program℠ may qualify the patient to receive a three month supply of Pertzye® free of charge. Promptly after this enrollment form is received, DCI will review the information and if enrollment is approved, DCI will send a free three month supply of Pertzye® to the requesting physician. The free product will be labeled with the Patient's name and sent to the physician for distribution to the patient. DCI will maintain the confidentiality of patient information with appropriate safeguards as required by law and by the physician's privacy practices. DCI may use patient information for marketing purposes. DCI reserves the right to withdraw or cancel this offer at any time without notice. The Pertzye® Assistance Program℠ is subject to availability of products and does not constitute an entitlement.

Patient Name (please print): Patient Signature:

IF PATIENT IS A MINOR Parent/Guardian/Guarantor Name (please print):

Parent/Guardian/Guarantor Name Signature: Date:

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