

The Theravance Biopharma Patient Assistance Program is designed to assist financially disadvantaged individuals that have no private or public insurance coverage such as Medicaid, Medicare prescription drug coverage, state- sponsored prescription drug assistance, employee, military, retirement or pension program drug coverage.

**PATIENT ELIGIBILITY CRITERIA (patient must meet all of the criteria):**

- The patient must be a legal resident of the United States or its Territories.
- The patient must not be eligible for or have insurance coverage for VIBATIV<sup>®</sup> (telavancin) through any public, private or Medicare Part D prescription coverage program.
- The patient's annual household income must be at or below 300% of the current Federal Poverty Level.
- A copy of the patient's most recent Federal tax return must be submitted with the program application form. If the patient does not file a Federal tax return, alternate proof of income must be submitted.

**APPLICATION PROCESS:**

- Complete the enclosed application in its entirety. **Incomplete applications will be denied.**
- Applications must be submitted within 120 days from the start of the patient's treatment.
- Submit the application to the fax number listed at the top of the application form.
- Include a copy of the patient's most recent federal tax return. If the patient does not file a federal tax return, alternate income documentation must be provided. The documentation must support the Total Annual Income value listed on the application form. Acceptable document types include: W-2 forms, pay statements, Social Security award letter, pension or retirement statements, bank statements, and statements of interest, dividends, or other income.

*Note: If this documentation is not available to support the income reported by the patient, the Institution or authorized Institution Contact, a written letter **must** be submitted from the Institution providing the reason(s) these documents may not be available for review under the program. All applications received without the supporting documentation required will be reviewed on a case by case basis.*

- All applications must be submitted with proof of product(s) dispense from the treatment facility's pharmacy and proof that patient received the product(s) covered by this Program. Documentation to support this request includes but is not limited to the following document type/format: A written script from the doctor on the day the treatment was started, Pharmacy dispensing log, patient account summary (listing medications dispensed), patient chart notes, etc.
- A program representative will evaluate the application using pre-established program guidelines to determine eligibility.
- The treatment facility will be notified by phone and fax regarding the outcome of acceptance into the program.

**Patient Assistance Program Application**

PATIENT INFORMATION					
Name:			Phone Number:		
Street Address:					
City:		State:		Zip Code:	
Date of Birth:		SSN#:		Gender: <input type="checkbox"/> F <input type="checkbox"/> M	Weight (kg):
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				US Resident: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Patient Has Insurance: Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, attach a copy of insurance card(s))			ICD-10-CM Code(s):		
Treatment Start Date:			Treatment End Date:		
FINANCIAL INFORMATION					
Total Annual Household Income: \$ _____					
Total Number of people in household dependent upon income provided (including patient): _____					
Attachments: <input type="checkbox"/> Most Recent Federal Tax Return <input type="checkbox"/> W-2 <input type="checkbox"/> Pay Statements ( past 3 months) <input type="checkbox"/> Social Security Award Letter <input type="checkbox"/> Other _____					
REFERRING PHYSICIAN INFORMATION					
Physician Name:			Specialty:		
Hospital / Facility Name:			Email:		
Street Address:			Phone #:		
City:		State:		Zip Code:	
SHIPPING ADDRESS FOR REPLACEMENT VIALS					
<input type="checkbox"/> Physician Office	<input type="checkbox"/> Hospital Outpatient	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Infusion Center		
<input type="checkbox"/> Home Health	<input type="checkbox"/> Hospital Inpatient	<input type="checkbox"/> Long-term Care Facility	<input type="checkbox"/> Other _____	<i>(please specify)</i>	
Facility Name:					
Street Address:					
City:		State:		Zip Code:	
Facility Contact Name / Title:			Department:		
Phone #:		Fax #:		Email:	
NPI:		Tax ID #:		DEA #:	License #:
			<b>Number of Vials Administered</b>		
VIBATIV <sup>®</sup> (telavancin) for injection 250mg vial			_____		
VIBATIV <sup>®</sup> (telavancin) for injection 750mg vial			_____		
CERTIFICATION AND CONSENT					
<p><i>I certify that the information above is accurate and complete and the above patient has financial need. I have received consent from the patient or the patient's guardian to enroll the patient in the Theravance Biopharma Patient Assistance Program. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the data to the Theravance Biopharma's Assistance Program's authorized representative. I further represent that this patient has no insurance coverage for VIBATIV, including all public programs. My signature certifies that no other submissions for payment for product(s) provided under the program will be made to any private, federal or state healthcare program or the patient.</i></p>					
Authorized Signature: _____					Date: _____
Name (print): _____			Title: _____		

Access VIBATIV  
2730 S. Edmonds Lane, Suite 300  
Lewisville, Texas 75067

# Fax Cover Sheet

**To:** \_\_\_\_\_ **Company:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_  
**Total Pages:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Subject:** \_\_\_\_\_

**Comments:**

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Memo:

Please see full Prescribing Information including Warnings, Precautions, and Adverse Reactions at [www.vibativ.com](http://www.vibativ.com).

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