



Alaven Assistance Program
PO Box 42886 - Cincinnati, OH 45242
Phone: 800-593-7923 - Fax: 513-618-0053
Email: alaven@rxhope.com

Physicians can apply online at www.RxHope.com/Alaven

■ **ELIGIBILITY REQUIREMENTS**

- **Application must be filled out in its entirety by the Patient and Healthcare Provider**
- **Patient and Healthcare Provider must sign and date the application**
- **Patient must have an income at or below 200% of the Federal Poverty Level**
- **Patient must not have coverage through any Medicaid, Medicare, Medicare Part D or Private Insurance**

■ **INCOME VERIFICATION**

- **Patient must attach a copy of the most recent household income documentation**
Acceptable forms of documentation include:
 - **Copy of U.S. Income Tax Return, IRS Form 1040, 1040A, 1040EZ, 1040NR or 1040 PR**
 - **Copy of Social Security/Disability Award Letter, Benefit Statement, or Monthly Check**
 - **Copy of most recent pay stub**
- **If the patient is unable to provide documentation of income, the Healthcare Provider may attest to the patient's need by attaching a letter stating that patient has no income and is unable to afford the requested medication.**



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PHYSICIAN INFORMATION

Physician Name (Last, First, MI) _____ Designation _____
 DEA # (Required)* _____ State License # _____ Exp _____
 DEA Address _____
 City _____ State _____ Zip Code _____ Email _____
 Telephone _____ Fax _____ Contact _____

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature _____ Date _____

***Anadrol®-50 must be shipped to DEA Address**

PRODUCT INFORMATION



Please Attach a Prescription for Anadrol

Please indicate number of tablets per day:
 ___ 1 ___ 2 ___ 3 Refills: ___

- 50mg tablets
- A 30-day supply is provided



Please indicate supply amount:

- 4-Weeks of Therapy
- 8-Weeks of Therapy

PATIENT INFORMATION

Patient First Name _____ MI _____ Last Name _____
 Address _____ City _____
 State _____ Zip _____ Marital Status: S M D W Other
 Telephone _____ Date of Birth (MM/DD/YYYY) _____ Male Female
 Social Security # _____ Are you a U.S. Resident? Y N Are you a Veteran? Y N
 Number of Persons in Household _____ Household Gross Income* \$ _____

*Documentation Required. See Instructions Sheet for Acceptable Proof of Income Documentation

Do you have Prescription Drug Coverage? Yes No Are you enrolled in Medicaid? Yes No
 Are you enrolled in Medicare Part D? Yes No

I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of the program. I hereby authorize the patient assistance program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature _____ Date _____

Fax completed application to 513-618-0053 or Mail to the address above