VIBATIV®
(telavancin) for injection

Theravance Biopharma
Patient Assistance Program
Phone: 855-847-9435 Fax: 855-847-9478

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® 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.

Please see full Prescribing Information including Warnings, Precautions, and Adverse Reactions @ www.vibativ.com

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THERAVANCE BPH-VBT 00175-02 11/2016

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Patient Assistance Program Application

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PATIENT INFORMATION

Name: | Phone Number:
Street Address:
City: | State: | Zip Code:
Date of Birth: | SSN#: | Gender: ☐ F ☐ M | Weight (kg):
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | US Resident: Yes ☐ No ☐
Patient Has Insurance: Yes ☐ No ☐ *(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: ☐ Most Recent Federal Tax Return ☐ W-2 ☐ Pay Statements (past 3 months) ☐ Social Security Award Letter ☐ Other

REFERRING PHYSICIAN INFORMATION

Physician Name: | Specialty:
Hospital / Facility Name:
Street Address: | Phone #:
City: | State: | Zip Code:

TREATMENT FACILITY INFORMATION

☐ Physician Office ☐ Hospital Outpatient ☐ Skilled Nursing Facility ☐ Infusion Center
☐ Home Health ☐ Hospital Inpatient ☐ Long-term Care Facility ☐ Other ____________ *(please specify)*

Facility Name:
Street Address:
City: | State: | Zip Code:
Facility Contact Name / Title: | Department:
Phone #: | Fax #:
NPI: | Tax ID #: | DEA #: | License #:

CREDIT REQUEST

Wholesaler Name: | Wholesaler Account #:
Wholesaler Complete Address:
Wholesaler Phone #: | Wholesaler Fax #:

	Number of Vials Administered	Amount Paid Per Vial
VIBATIV® (telavancin) for injection 250mg vial		$
VIBATIV® (telavancin) for injection 750mg vial		$

CERTIFICATION AND CONSENT

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.

Authorized Signature: ____________ Date: ____________

Name (print): ____________ Title: ____________

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