PATIENT ASSISTANCE PROGRAM

Any assistance provided is temporary; there is no implied commitment to continue providing product on an extended basis to any individual patient. Under no circumstances is product supplied under patient support to be sold. Billing private (e.g. health insurer) or public (e.g. RAMQ) health care providers for the product supplied by Paladin Labs is strictly prohibited.

Please fill out this form and fax back to 514-344-4675 or e-mail PDF to PaladinCS@paladinlabs.com

- **Physician Name:** _____
- **Medical License number:** _____
- **Office Address** (full address with postal code):

  _____

  _____

  _____
- **Office telephone number:** _____
- **Patient Initials:** _____
- **Product Requested & Dosage:** _____
- **Indication:** _____

☐ I, the treating physician, certify that to the best of my knowledge and after due inquiry, the patient listed above does not have the financial means to purchase the requested product. Additionally, to the best of my knowledge, the patient has exhausted alternative options of obtaining care. (physician initials box).

☐ I, the treating physician, certify that I have provided the patient the product information. (physician initials box).

Physician Signature/Date:

_____

By signing this form, I certify that all information provided is complete and accurate.

Please note that the request will not be taken into consideration if any of the above information is missing. If you wish to be informed of the status of this request, kindly leave an e-mail and you will be contacted shortly. Thank you for your cooperation.