



2615 E Randolph Ave.
Enid, OK 73701
580-242-7928 Fax 580-234-3554
www.cdsaok.org

RX FOR OKLAHOMA

This program is to assist client/patients without prescription drug coverage. These programs offer client patient maintenance drugs by Pharmaceutical Companies for the “medical needy”. The Prescription Assistance Program was created to make it easier for uninsured or underinsured patients to get free or nearly free prescription medicine. Each patient assistance program has its own eligibility criteria. In addition to prescription benefits status (any prescription drug coverage or eligible for coverage) household income and size, the criteria for some programs require additional information.

Information Necessary for Application

Please provide the following information to process the application.

- Application Form
- Prescription Form
- Patient Consent and Release Form
- Information Form
- Proof of Income
 - ❖ 1 months pay stubs, if employed
 - ❖ Most recent income tax return
 - ❖ Unemployment/workers comp. Documentation
 - ❖ SSR, SSI, SSD, Pension/Retirement
 - ❖ Public Assistance (TANF)
 - ❖ Rental Income
 - ❖ Veteran’s benefits or other course of income
- Any Insurance Cards, copy of front and back, to include health insurance and/or prescription coverage, Medicaid or Medicare.
- Denial Letter certifying ineligibility for Medicare/Medicaid, state health insurance, veteran’s or any other health insurance coverage.

****Note:** Please mail back the highlighted or marked information to our office.

If you do not have an income, please write a statement explaining your current situation.

Thank you,

Rx for Oklahoma Staff



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Dear Client:

Certain pharmaceutical companies offer patient assistance programs to patients without prescription insurance coverage and/or cannot afford their medications and qualify under specific guidelines. Our program will handle the majority of the paperwork for you. You may be required to complete an application or answer a few questions by either the pharmaceutical company or our program.

While we do our best to locate assistance, we ask that you do your part in supplying the necessary documentation required to complete the application in a prompt and efficient manner.

We will try our best to secure free or discounted medications on your behalf, however, each pharmaceutical company has its own policies and financial guidelines that we must adhere to. Below are a few of the things that we expect from you to help with the process:

- Provide proof of income. This can be a copy of last year's tax return, a copy of your Social Security benefit statement, copies of your last four pay stubs or documentation that the pharmaceutical company stipulates.
- If you are not accepted into an assistance program, a denial letter will notify you. If approved, the medication will be shipped directly to your home or to your doctor's office and you will have to sign for it. Most medication are for 90-days or less.
- Notify our office when you have a 30-day supply of medication. This will ensure that you receive your refill in a timely manner. It can take the pharmaceutical company as long as four weeks to issue a refill. If you do not notify our office within this time frame, you may run out of medication.
- Notify our office if your financial or insurance situation changes.
- Over the counter medications **are not** offered by the assistance programs.

We ask that you read this document carefully and sign if you understand and agree to comply with these requirements.

Client Signature

Date



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Rx for Oklahoma

Patient Consent and Release Form

Exchange of Information

I give permission to authorized representatives of Rx for Oklahoma to inspect my medication records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize participating drug companies to discuss my medical needs with my physician/prescriber when necessary. This authorization is good as long as the above named program is operational or until I revoke such.

I agree that a copy of this form can be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency, company or organization individually to give them information they may need.

Date of Birth: _____ **Social Security Number:** _____

Address: _____

Printed Name of Client: _____

Signature: _____ **Date:** _____

Patient Signature Authorization

I authorize representatives of Rx for Oklahoma to sign forms on my behalf for the purpose of soliciting medications from companies that manufacture or provide medications through patient assistance programs. This signature is good as long as the above names program is operational or until I revoke such.

Printed Name of Client: _____

Patient Signature: _____ Date: _____



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Release of Confidential Information Form

The **Prescription Assistance Service, *Rx for Oklahoma***, is designed to address the medication needs of individuals in our community. This program participates with pharmaceutical manufacturers to offer assistance and provide medications to low-income or uninsured people. These medication manufacturers often require personal demographic, therapeutic, and financial information as part of the application process. For your convenience, we are requesting your permission to access and provide the manufacturers with the requested medical and financial information, as needed.

By signing this statement you authorize the Prescription Assistance Service, *RX for Oklahoma*, to complete any and all forms and applications on your behalf, and to access and release any personal demographic, therapeutic, and/or financial information relating to applications for drug manufacturer assistance programs. This authorization may be revoked at any time by contacting **CDSA**, the Prescription Assistance Service, *Rx for Oklahoma*, at 580-242-7928. The individual signing this document reserves the right to appeal any decision made regarding assistance provided by Rx for Oklahoma and participating partners. The right to appeal does not guarantee the right to modify individual pharmaceutical company policies and procedures.

Client Signature

Date

This program is provided through a joint effort of Community Development Support Association (CDSA), the Oklahoma Department of Commerce and the State of Oklahoma with special thanks to the Oklahoma Pharmacy Connection Council.

Region 1 - Rx for Oklahoma

Located: CDSA

2615 E. Randolph, Enid, OK 73701

Phone: 580-242-7928

Fax: 580-234-3554

Toll Free: 1-877-794-6552

****MUST HAVE COPY OF INSURANCE CARDS & FINANCIAL VERIFICATION TO PROCESS****

Date: _____

Have we assisted you before? Yes No

Client Information:

Name: _____
(First) (MI) (Last)

Street Address: _____

City: _____ State: Oklahoma Zip: _____ County: _____

Phone: (580) _____

SSN: _____ - _____ - _____ Sex: M / F Date of Birth: _____

Race: _____ Marital Status: _____ Education Level: _____

Household: _____ Head _____ Spouse _____ Dependent Child _____

Employment Status: Full _____ Part _____ Not in Labor Force _____ Retired _____ Unemployed _____

Number in household: Adults _____ Children _____ Housing: Own Rent Stay with Family/Friends

Are you a U.S. Citizen? YES / NO Are you disabled? YES / NO Do you have V.A. benefits? YES / NO

How did you hear about this program?

Action Agency	Area-wide Aging Agency	Legislative Office	Community Clinic
Flyers	Newspaper	Social Services	Hospital
DHS	Friend/Family	TV/Radio	Employer
Doctor's Office	Health Department	Website/Internet	Other _____

Insurance Information:

PLEASE COPY & ATTACH all insurance cards, front & back. Including Medicare & Medicaid.

Medicare (Medicare # _____) Medicare Discount Card Medicaid

Private Health Insurance (Company _____) None

Do you have prescription insurance? YES NO

Financial Information:

PLEASE Enter your MONTHLY household income from all sources.

i.e. income tax return, SS benefit statement, bank statement, check stubs for entire month

If you currently do NOT have any income, please provided a statement explaining your situation.

Wages:\$ _____ Unemployment:\$ _____ Workers Compensation:\$ _____

SS Retirement:\$ _____ SS Disability:\$ _____ Other Disability:\$ _____

Retirement:\$ _____ Alimony/Child Support:\$ _____ Other:\$ _____

Food Stamps:\$ _____ TOTAL MONTHLY HOUSEHOLD INCOME: \$ _____

Did you file a tax return last year? YES NO

Will you file a tax return this year? YES NO

Primary Physician Information:

Physician Name: _____ **Phone:**(____) _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If no please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If no please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If no please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If no please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If no please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____



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New Client Questionnaire:

Date: _____

1. How did you hear about the Rx for Oklahoma program?
 - a. Community Action Agency
 - b. Community Clinic
 - c. DHS
 - d. Doctor's Office
 - e. Family/Friend
 - f. Flyer/Brochure
 - g. Hospital
 - h. Presentation
 - i. Social Services
 - j. TV/Radio
 - k. Billboard
 - l. Website/Internet Search
 - m. Word of Mouth
 - n. Newspaper
 - o. Other: _____

2. Approximately, how much do you spend monthly on your medications?
 \$0-\$50 \$51-\$100 \$101-\$200 \$201-\$300
 \$301-\$400 \$401-\$500 over \$500

3. How have you been getting your medications?

<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Samples from doctor
<input type="checkbox"/> DHS/SoonerCare	<input type="checkbox"/> Free Clinic
<input type="checkbox"/> Manufacturer	<input type="checkbox"/> Not able to get
<input type="checkbox"/> Pay cash	<input type="checkbox"/> Other
<input type="checkbox"/> \$4 program at Wal-Mart	

4. Age: 0-20 21-40 41-64 65-80 81+

5. Gender: Male Female