



**Partnership for  
Prescription Assistance**



**Because millions of people need help  paying for medicine**





## Who We Are

- The Partnership for Prescription Assistance (PPA) is a collaboration of:
  - America's pharmaceutical research companies
  - Healthcare providers
  - Patient advocacy organizations
  - Civic groups



## A Number of People Needed Help Accessing Prescription Medicines

In 2005, more than 29 million Americans were uninsured and earned less than 200% of the Federal Poverty Level (*\$40,000 annual income for a family of four*).

America's pharmaceutical research companies have provided help to the uninsured and underinsured for more than 50 years through patient assistance programs (PAPs).

Millions of people have been helped by industry-sponsored and federal assistance programs.

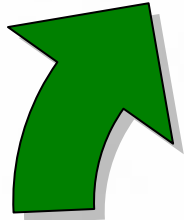
However, too few are aware of the help they can receive or that PAPs even exist.



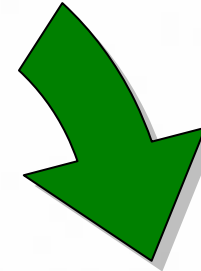
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# We Saw an Opportunity to Help

*... Create a Clearinghouse*

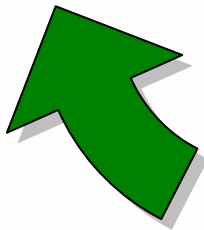


**Provide Americans with a  
single point of access to  
existing patient  
assistance programs**

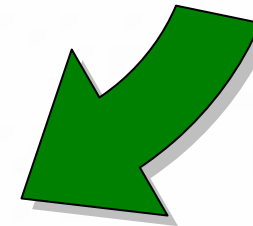


**Raise awareness of  
and increase  
participation in  
patient assistance  
programs**

**Make it easier for  
providers and  
partners to help  
patients in need**



**Make it easier for  
patients to apply for  
programs which  
they may qualify**





## How the PPA Works

- ✓ Provides patients with **a single point of access** to more than 475 public and private patient assistance programs, including more than 180 programs sponsored by pharmaceutical research companies, through a toll-free number (**1-888-4PPA-NOW**) and user-friendly Web site (**[www.pparx.org](http://www.pparx.org)**)
- ✓ Provides **access to more than 2,500 brand-name prescription medicines**, and a wide-range of generic medicines
- ✓ Makes it **easier for patients to learn about and apply for** patient assistance programs
- ✓ Raises **awareness of public and private patient assistance programs**, including Medicare, SCHIP and Medicaid
- ✓ **Connects patients to free healthcare clinics and providers** in their communities



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# The PPA is Easy to Use for Patients and Health Care Providers

**Figure 1. Partnership for Prescription Assistance Enrollment and Application Process**



- Patients can contact the PPA through a toll-free number or user-friendly Web site and this service is free.
- Trained specialists are available to help patients through the process. The call center can accommodate 150 languages.
- To find out if there are programs that may meet their needs, patients have to answer a short series of questions.
- All information is confidential.
- While each program varies, it usually takes 2 to 3 weeks for patients to receive their medicines once they have completed the application process.



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Patients can use  
the Web Site

... [www.pparx.org](http://www.pparx.org)

1-888-4PPA-NOW (1-888-477-2669)

[Patient FAQs](#)

[English](#)

[Español](#)



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[ABOUT US](#)

[PRESCRIPTION ASSISTANCE PROGRAMS](#)

[NEWS & MEDIA](#)

TEXT-SIZE: [A](#) [A](#) [A](#) [EMAIL](#) [PRINT](#)



### I GOT HELP

"When my life hit rock bottom the Partnership for Prescription Assistance helped me. With the PPA, I receive my prescription medicines. It saved my life and now I can smile again.

[Read My Story](#) | [Read Other's Stories](#)

### YOU CAN GET HELP

- More than 2,500 medicines
- 475 patient assistance programs

[GET HELP NOW!](#)

OR CALL TOLL-FREE  
1-888-4PPA-NOW (1-888-477-2669)  
TO SEE IF YOU ARE ELIGIBLE



**6.5 million helped in 5 years.**

**GET HELP NOW!**

**Use a Blackberry or iPhone to search for programs**



**New!**

MORE RESOURCES FOR:

[PATIENTS](#)

[PATIENT ADVOCATES](#)



# Select your Medicines

## 1 Step 1: Tell Us What Medicines You Take [Frequently Asked Questions](#)

The first step to find out which patient assistance programs you may qualify for is to search for and pick out your medicines.

To begin, type the name of your medicine into the box and click the search button. Once the search is complete **you can add one or more prescription drugs from your search to the My Medicines list** which appears on the right side of the page. Repeat this process until you have entered and selected all of your medicines.

To ensure your privacy the Partnership for Prescription Assistance will never save your search data. For more information, see our [privacy policy](#).

Search for Drug:

Please review the "My Medicines" list to the right.

If you need to add a medicine to the "My Medicines" list, enter it into the search box above, or select another drug from your existing search below.

If you have selected a medicine in error, please select the "Remove" button next to that medicine in the "My Medicines" list.

If you've selected ALL of the medicines you take, select "Next."

SEARCH RESULTS		MY MEDICINES	
Nexium®	esomeprazole magnesium 20 mg and 40 mg	Already Added	Nexium® <input type="button" value="REMOVE"/>
Nexium® I.V. Injection	(esomeprazole sodium)	<input type="button" value="Add to My Medicines"/>	
Nexium® Oral Suspension	esomeprazole magnesium	<input type="button" value="Add to My Medicines"/>	





# Add Each Medicine

1

## Step 1: Tell Us What Medicines You Take [Frequently Asked Questions](#)

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### SEARCH RESULTS

Paxil CR®

paroxetine hydrochloride

Already Added

### MY MEDICINES

Nexium®

REMOVE

Lipitor®

REMOVE

Synthroid® Tablets

REMOVE

Paxil CR®

REMOVE

< PREVIOUS

NEXT >



# Answer a Few Questions

## 2 Step 2: Tell Us About Yourself [Frequently Asked Questions](#)

Please answer these short questions to see which patient assistance programs you may qualify for. You must answer ALL questions on this page to be considered. If you need assistance, please call 1-888-477-2669.

What is your age?

What is your zip code?

How many people are in your household?

**Total combined income** for people in your household? **Monthly: \***  **OR** **Yearly: \***   
 (Where can I find this?)

What is your current residency status?  
 U.S. citizen  
 Legal resident of the U.S.  
 Other

Are you pregnant?  
 No  
 Yes

Are you eligible for any of the following?  
 Medicare  
 VA or Military Benefits  
 State Insurance  
 None  
 Medicaid  
 HMO/PPO  
 Private Insurance  
 I do not know

Please check all that apply.

How did you hear about PPARx?

< PREVIOUS

NEXT >

**MY MEDICINES LIST**

- Nexium®
- Lipitor®
- Synthroid® Tablets
- Paxil CR®

[Edit My Medicines List](#)



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### Step 3: Your Results

[Frequently Asked Questions](#)

According to the information you entered, you may be eligible for one or more of the programs listed below.

Click the "More Information" link next to a program to learn more.

Click the "Select Program" check box next to any program that you would like to apply to.

Click the "Next" button at the bottom of the page after you have selected the programs you would like to apply to.

# Get Results!

SELECT PROGRAMS	PROGRAM AND PROVIDER	QUALIFYING MEDICINE(S)
<input checked="" type="checkbox"/>	<b>Abbott Patient Assistance Foundation</b> <b>Abbott</b> <a href="#">More Information</a>	<b>Synthroid® Tablets</b>
<input checked="" type="checkbox"/>	<b>AZ&amp;Me™ Prescription Savings Program for people with Medicare Part D</b> <b>AstraZeneca</b> The AZ&Me Prescription Savings program for people with Medicare Part D is designed to provide AstraZeneca medicines at no cost to qualified patients enrolled in a Medicare Part D prescription drug coverage plan but who are having difficulty affording their AstraZeneca medicine(s). Highlights 1. AstraZeneca medicines provided at no cost 2. There is NO cost to sign up for this program 3. Enrollment is on a calendar year basis 4. Mailed to the home or physician's office 5. You or your doctor can request refills 6. Convenient online self-service tool to enroll, re-enroll, check enrollment or shipment status or to request a refill Are you eligible? If you are enrolled in Medicare Part D, you may be eligible for the program if you meet the following criteria: 1. Enrolled in Medicare Part D; 2. You are an individual with an annual income at or below \$30,000, or if a couple, at or below \$40,000; 3. You are taking an eligible AstraZeneca medicine; and Your household has spent at least 3% of annual household income on out-of-pocket costs on prescription medicines within the calendar year How to apply The AZ&Me Prescription Savings program for people with Medicare Part D offers an easy application process that can help you receive your AstraZeneca medicines quickly. To apply to the Program: Download the application ( In English   En Espa�ol), enroll online, or call 1-800-AZandMe (292-6363).	<b>Nexium®</b>



# Print Applications

## 4 Step 4: Complete and Mail Your Applications [Frequently Asked Questions](#)

You chose to apply to the following programs:

- Abbott Patient Assistance Foundation
- AZ&Me™ Prescription Savings Program for people with Medicare Part D
- AZ&Me™ Prescription Savings Program for people without insurance
- Bridges to Access
- Pfizer MAINTAIN™
- Together Rx Access

After you have printed your applications, please follow the directions included with each one carefully. Note that for some applications you will contact the sponsoring drug company; for others, you may need to have your doctor fill out the form and sign it before it can be mailed.

When you have completed each application, mail them to the address listed on each form. (Each application will have a separate address.) After you have completed and mailed in your applications, each program you applied to will contact you.

**If you are using a public computer and you have filled in personal data using the online form, please make sure you know where your documents will print to as these forms contain your personal information.**

### There are two ways you can get your applications:

1. Save them on your computer now and print them.
2. We can email them to you.

#### Now, to get your applications, choose one method below:



Download and save applications on your computer and then print

DOWNLOAD



Email me a blank application.

Email address: \*

SUBMIT

← PREVIOUS

**Patients call a toll-free number**



**1-888-4PPA-NOW  
(1-888-477-2669)**



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**Trained specialists help them  
through the application process**

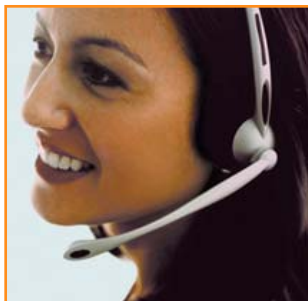




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## Application forms are mailed to the caller

<p><b>For Valid Application:</b> 1. Application must be complete. 2. Start-Up Option purchased must be indicated. 3. Application must be signed by Applicant. 4. If faxed (Fax #620-793-4523), original must be received in Distributor Service Center within 10 days.</p> <p><b>PLEASE PRINT OR TYPE.</b> Date: _____</p> <p>Name: _____ Spouse's Name: _____ Address: _____ City: _____ State: _____ Zip: _____ County: _____ Phone # (Day): ( ) _____ Phone # (Other): ( ) _____ Shipping Address (if different from above): _____ City: _____ Address: _____ City: _____ State: _____ Zip: _____ County: _____ Directions: _____</p> <p>Social Security # or (if incorporated) Federal ID #: _____ Spouse's SS #: _____</p> <p>If you are responsible for your own sales tax reporting, please call Customer Service (Ext. 280) prior to submitting an order.</p> <p><b>Optional demographic information only:</b> Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: _____</p> <p><b>Before signing this Agreement, please read all terms and conditions on the reverse side.</b></p>	<p><b>Senior Sponsor's and Sponsor's Use Only (Print)</b></p> <p>Sponsoring Distributor: _____ Sponsor's Acct. No.: _____ Senior Sponsor's Acct. No.: _____ Sponsoring Distributor: _____ Senior Sponsor's Acct. No.: _____ All items must be completed. Senior Sponsor (initial and/or contact) may be same Distributor as Sponsor.</p> <p><b>You must indicate which Start-Up Option is to be shipped and include the full required payment:</b> The only requirement to becoming a Fuller Brush Independent Distributor is a signed application and the purchase of a Business Starter Kit (without product). There are <b>optional</b> combinations of Starter Kits and products offered to Distributors who wish to immediately begin using and reselling the products. Please indicate the kit you wish to purchase and the price including applicable sales tax and handling charge.</p> <table border="1"><thead><tr><th>#</th><th>Kit Item #</th><th>Description</th><th>Total Amount Due</th></tr></thead><tbody><tr><td><input type="checkbox"/></td><td>\$150 Retail (less Discount)</td><td>Auto Order Pack</td><td></td></tr><tr><td><input type="checkbox"/></td><td>\$35 Retail (less Discount)</td><td>Auto Order Pack</td><td></td></tr></tbody></table> <p>I want my Auto Order to be effective in _____ (month) (Must be current month or next month)</p> <p><b>You must check payment option:</b></p> <p><input type="checkbox"/> Please send my kit (and Auto Order Pack if applicable) Bill me: <input type="checkbox"/> MC <input type="checkbox"/> Visa <input type="checkbox"/> Discover Card # _____ Exp. _____</p> <p><input type="checkbox"/> Please send my kit. Enclosed is my money order or cashier's check for \$ _____ made payable to The Fuller Brush Company.</p> <p><input type="checkbox"/> I purchased my starter kit, serial # _____ from my sponsor. (Serial # must be noted if this option is used.)</p> <p>I agree to the terms of the Independent Distributor Agreement form. I have received or ordered a Fuller Brush Distributor Business Starter Kit and I agree to pay Fuller the amount due each order as outlined in the Independent Distributor Agreement.</p> <p><b>Signature is required.</b> Applicant's Signature: _____ Spouse's Signature: _____ I, the undersigned sponsor, agree the above listed Senior Sponsor (initial and/or contact) will receive the Frequent Fuller Award Points based on product volume. Sponsor's Signature: _____ Send the whole copy of this Agreement to: The Fuller Brush Company, One Fuller Way, Great Bend, KS 67530</p> <p><small>White Copy - Company • Yellow Copy - Sponsor • Pink Copy - Distributor</small></p>	#	Kit Item #	Description	Total Amount Due	<input type="checkbox"/>	\$150 Retail (less Discount)	Auto Order Pack		<input type="checkbox"/>	\$35 Retail (less Discount)	Auto Order Pack	
#	Kit Item #	Description	Total Amount Due										
<input type="checkbox"/>	\$150 Retail (less Discount)	Auto Order Pack											
<input type="checkbox"/>	\$35 Retail (less Discount)	Auto Order Pack											





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# Patients bring the forms to their healthcare provider



<p><b>Pay Method Application</b></p> <p>1. Complete this application for: a. Payment of your copayments b. Payment of your deductibles c. Payment of your coinsurance d. Payment of your out-of-pocket maximum e. Payment of your out-of-network costs f. Payment of your out-of-state costs g. Payment of your out-of-country costs h. Payment of your out-of-network costs i. Payment of your out-of-state costs j. Payment of your out-of-country costs</p> <p><b>Pay Method Application</b></p>	<p><b>Service Sponsor is and Sponsor is the Only Party</b></p> <p>1. I am the only party who can authorize the use of my insurance for the purpose of this application. 2. I am the only party who can authorize the use of my insurance for the purpose of this application. 3. I am the only party who can authorize the use of my insurance for the purpose of this application. 4. I am the only party who can authorize the use of my insurance for the purpose of this application. 5. I am the only party who can authorize the use of my insurance for the purpose of this application. 6. I am the only party who can authorize the use of my insurance for the purpose of this application. 7. I am the only party who can authorize the use of my insurance for the purpose of this application. 8. I am the only party who can authorize the use of my insurance for the purpose of this application. 9. I am the only party who can authorize the use of my insurance for the purpose of this application. 10. I am the only party who can authorize the use of my insurance for the purpose of this application.</p>
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Before signing this Agreement, please read all terms and conditions on the reverse side.





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# Patients receive their medicines



<p><b>For Patient Application</b></p> <p>1. Complete this form for each prescription you wish to apply for. 2. Attach a copy of your prescription to this application. 3. Complete this form for each pharmacy you wish to use. 4. Attach a copy of your insurance card to this application. 5. Attach a copy of your driver's license to this application. 6. Attach a copy of your photo ID to this application. 7. Attach a copy of your Social Security card to this application. 8. Attach a copy of your bank statement to this application. 9. Attach a copy of your utility bill to this application. 10. Attach a copy of your recent pay stub to this application.</p>	<p><b>Service Sponsor is and Sponsor is the Only Party</b></p> <p>1. I am the Service Sponsor and I am the only party responsible for the payment of the prescription. 2. I am the Sponsor and I am the only party responsible for the payment of the prescription. 3. I am the Sponsor and I am the only party responsible for the payment of the prescription. 4. I am the Sponsor and I am the only party responsible for the payment of the prescription. 5. I am the Sponsor and I am the only party responsible for the payment of the prescription.</p>
<p><b>Name</b> _____</p> <p><b>Service Sponsor Name</b> _____</p> <p><b>Address</b> _____</p> <p><b>City</b> _____ <b>State</b> _____ <b>Zip</b> _____ <b>County</b> _____</p> <p><b>Phone # (Home)</b> _____</p> <p><b>Phone # (Work)</b> _____</p> <p><b>Shipping Address (if different from above)</b> _____</p> <p><b>Address</b> _____</p> <p><b>City</b> _____ <b>State</b> _____ <b>Zip</b> _____ <b>County</b> _____</p> <p><b>Business</b> _____</p> <p><b>Special Services/ID</b> _____</p> <p><b>Sponsor's Signature</b> _____</p>	<p><b>You must check payment option</b></p> <p><input type="checkbox"/> I will pay for my prescription out of pocket.</p> <p><input type="checkbox"/> I will pay for my prescription out of pocket.</p> <p><input type="checkbox"/> I will pay for my prescription out of pocket.</p> <p><input type="checkbox"/> I will pay for my prescription out of pocket.</p> <p><input type="checkbox"/> I will pay for my prescription out of pocket.</p>
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# Since Its Launch in April 2005, the PPA Has Been Extremely Successful in Raising Awareness and Helping Patients

**Over 6.5 Million  
Patients Helped**



**Delores McAllister, DE**

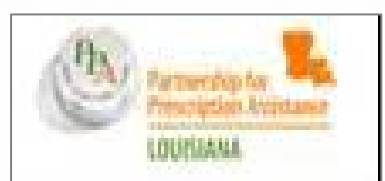


**Pradeep Kharel, MN**



**Melannie Godfrey, AR**

**PPA Chapters  
Launched in All  
50 States**



**More Than 1,300  
Partners Have  
Joined Forces**





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# PPA Operations Highlights

Number of calls to 1-888-4PPA-NOW	<b>3,735,211</b>
Number of Web searches on <a href="http://www.pparx.org">www.pparx.org</a>	<b>4,105,658</b>
Number of patients connected to patient assistance programs	<b>6,527,255</b>
Average percentage of matched	<b>85%</b>
Patients referred to free healthcare clinic or provider	<b>More than 245,000</b>



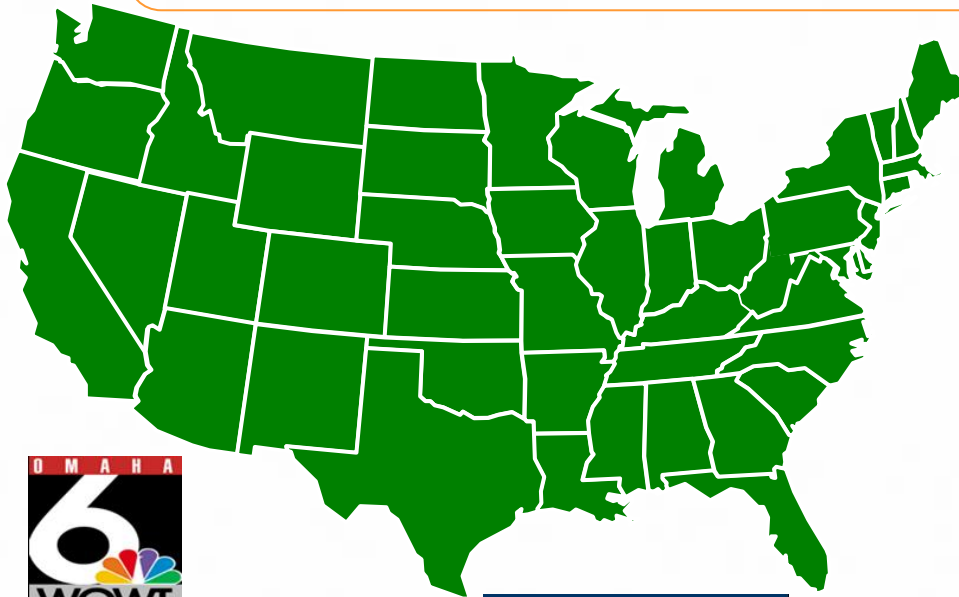
*\* Data as of April 21, 2010*



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## Chapters Launched in All 50 States

The PPA launched chapters in all 50 states, as well as Washington D.C. and Puerto Rico, to increase awareness of and boost enrollment in patient assistance programs.



Activities in the states included:

- Local press events & ongoing media outreach
- Partner recruitment
- Community outreach & program demonstration events
- Religious & minority outreach
- Distribution of brochures



Chicago Tribune

PalmBeachPost

PITTSBURGH TRIBUNE-REVIEW



The New York Times



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## Patients share their stories ... and Help Spread the Word



“It is so wonderful not to worry about whether or not I will get the medicine I need.”

-Colleen Thurman, Richland Hills, TX



“The PPA is a blessing and the program truly saved my life.”

-Vincent Payne, Walterboro, SC



“I did not know what to do until I found out about the PPA and I’m so thankful for how it has helped me.”

-Jo Davis, Truth or Consequences, NM



## What PPA partners are saying...

“The National Hispanic Medical Association applauds the PPA for supporting prescription drugs at affordable prices for Hispanic families so that they can lead quality lives”

– ***Elena Rios, President & CEO, National Hispanic Medical Association***

“What this program does is makes those programs accessible, which will then bring down the cost of the drugs for those that need them.”

– ***Tony Ross, President , United Way of America***

“It’s as if the Partnership for Prescription Assistance was designed with caregiving families in mind. It fills a very big need. It is straightforward and simple to use – it will allow caregiving families to quickly figure out what programs they are eligible for and apply for them.”

– ***Suzanne Mintz, President, National Family Caregivers Association***



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## How You Can Help us Further Reach Patients in Need ...

- ✓ Tell people about the Partnership for Prescription Assistance and direct them to the toll-free number (1-888-4PPA-NOW) and the Web site [www.pparx.org](http://www.pparx.org).
- ✓ Make patient education materials available in your office
  - Brochures are available in English and Spanish
- ✓ Spread the word, Spread the word, Spread the word!

**[www.pparx.org](http://www.pparx.org)**

**1-888-4PPA-NOW**