PLEASE NOTE THAT THE PATIENT ASSISTANCE PROGRAM PROVIDES PRODUCT TO FAMILIES IN FINANCIAL NEED.

FINANCIAL NEED IS DEFINED AS INDIGENT, FALLING BELOW THE 200% FEDERAL POVERTY LEVEL, OR EXPERIENCING FINANCIAL HARDSHIP SUCH THAT THE FAMILY CANNOT AFFORD TO PURCHASE THE PRODUCT.

PATIENTS WHO HAVE THE FINANCIAL MEANS TO PURCHASE
THE NESTLÉ PRODUCT
OR
WHO HAVE INSURANCE TO COVER IT
DO NOT QUALIFY.

PLEASE DO NOT SUBMIT APPLICATIONS FOR PATIENTS WHO ARE NOT IN FINANCIAL NEED AS THIS MAY IMPACT NESTLÉ'S ABILITY TO PROVIDE PRODUCT TO PATIENTS WHOSE MEDICAL WELL BEING OR LIFE IS DEPENDENT ON ITS PRODUCTS AND WILL NOT OTHERWISE BE ABLE TO OBTAIN THEM.

2017 ADULT PATIENT ASSISTANCE PROGRAM

Nestlé HealthCare Nutrition continues to experience great demand for products under its Patient Assistance Program. Due to the limited availability of funding for this Program, Nestlé HealthCare Nutrition limits its provision of products under the Program to patients who need its products to meet special medically determined nutrient requirements which cannot be achieved by modification of the normal diet alone and for whom the product is their only or primary source of nutrition. Patients who use the products as supplements are not eligible. These eligibility requirements are intended to help ensure that Nestlé HealthCare Nutrition is able to provide products to the patients most in need.

ELIGIBILITY REQUIREMENTS

The Adult Patient Assistance Program is designed to meet needs of patients (1) who are age 19 and older; (2) who do not have the financial resources or insurance coverage to pay for the product; (3) who have special medically determined nutrient requirements which cannot be achieved by modification of the normal diet; and (4) whose sole or primary source of nutrition is the requested product (100% of caloric needs).

In order to help insure that Nestlé HealthCare Nutrition is able to provide products to the patients most in need, patients who use the products as supplements are not eligible.

Please take note of the section of the application asking that the patient's healthcare provider certify that:

- The patient's sole or primary source of nutrition is the requested product (100% of the patient's caloric needs).
- The requested product will meet special medically determined nutrient requirements which cannot be achieved by modification of the normal diet alone.
- The patient is unable to pay for or receive reimbursement from any third party payers, including any medical insurance or government healthcare programs, for the product(s) requested.

Nestlé HealthCare Nutrition is unable to ship product to patients who reside outside of the U.S.

Please do not submit applications for patients who do not meet these criteria as this may impact Nestlé HealthCare Nutrition's ability to provide product at no charge to patients whose medical well being or life is dependent on its products.

How It Works:

- This form must be completed by the patient's healthcare professional. The selected product must be prescribed by the healthcare professional.
- The only products available on the Adult Program are those listed. The products are primarily intended for tube feeding; however, some of them may be tolerated orally.
- The Patient Assistance Program provides approved recipients with up to 12 cases of product per year in one shipment.
- The approval process usually takes about 48 hours after an application is received.
- The healthcare professional will be notified if the application is denied.
- If the healthcare professional is not notified of denial, the requested products will be delivered to the patient via UPS within 2 weeks after approval.

Instructions:

1. **The form MUST BE filled out in its ENTIRETY to be considered**. All sections must be completed.
2. **INCOMPLETE APPLICATIONS WILL BE AUTOMATICALLY DENIED.**
3. The form must be signed by the patient's healthcare provider and the patient or caregiver of the patient.
4. **DO NOT CALL.** The healthcare provider will be notified if the application is incomplete or denied.

NestléHealthScience

2017 Adult Patient Assistance Program

TO BE COMPLETED BY THE PATIENT'S HEALTHCARE PROFESSIONAL – MUST BE FILLED OUT COMPLETELY

Name of Patient: ______________________________ Age of Patient: ________

Please check each box below to certify that (If you cannot certify to each statement, the patient is not eligible):

- ☐ The patient's sole or primary source of nutrition is the requested product (**100% of the patient's caloric needs are met by the requested product.**) Estimated daily caloric intake of patient: __________ % caloric need to be met with the requested product: _________
- ☐ The requested product will meet special medically determined nutrient requirements which cannot be achieved by modification of the normal diet alone.
- ☐ **I am requesting a donation of goods for a person who is indigent, below the 200% Federal Poverty Level, or is experiencing severe financial hardship such that they are unable to pay for the product.**
- ☐ **The patient does not have any other means of paying for the product, including coverage by any medical insurance or government healthcare programs or alternative sources of funding.**
- ☐ There will be no attempt to bill any third party, including without limitation, any federal or state healthcare program, for any products supplied.

Step 2: Please CIRCLE the product being requested below:

GI Impaired Products		
Peptamen®	Unflavored	9871616269
Peptamen® 1.5	Vanilla	9871618190
Peptamen ® Prebio™	Vanilla	9871618185
Vivonex® RTF	Unflavored	36250000
Vivonex® T.E.N.	Unflavored	07127400
Vivonex® Plus	Unflavored	07129800
Tolerex®	Unflavored	04580500
GI Impaired Pediatric Products (if prescribed for the adult patient)		
Peptamen Junior®	Vanilla	9871616252
Peptamen Junior® Fiber	Vanilla	9871660210
Peptamen Junior® PreBio™	Vanilla	9871616261
Vivonex® Pediatric	Unflavored	07131000

Diabetic Products		
Diabetisource® AC	Unflavored	36500000
Glytrol®	Vanilla	9871616275
Severe Wounds Products		
IMPACT PEPTIDE® 1.5	Unflavored	4390097400
Standard Options		
Nutren® 1.5	Unflavored	9871616220
Nutren® 1.0 with Fiber	Unflavored	9871616056
Compleat®	Unflavored	14010000
Standard Pediatric Products (if prescribed for the adult patient)		
Nutren Junior®	Vanilla	9871616062
Nutren Junior® with Fiber	Vanilla	9871616063
Compleat® Pediatric	Unflavored	14240000

Name of Health Care Professional/Profession	
Institution/Office	
Practice Location (mailing address)	
Email Address (for application related correspondence only)	
Phone and Fax Numbers	

Licensed Health Care Professional Signature: ______________________________ **Date:** ______________

NestlēHealthScience

2017 Adult Patient Assistance Program

TO BE COMPLETED BY THE PATIENT OR THE PATIENT'S CAREGIVER – MUST BE FILLED OUT COMPLETELY

Please check each box below to certify that (If you cannot certify to each statement, the patient is not eligible):

- ☐ **I am indigent, below the 200% Federal Poverty Level, or due to severe financial hardship, am unable to pay for the product.**
- ☐ I have no medical insurance coverage, including Medicare, Medicaid, or WIC, for the product.
- ☐ There will be no attempt to bill any third party, including without limitation, any federal or state healthcare program, for any products supplied.
- ☐ I have read and agree to the Privacy Statement and Authorization set forth below.

Privacy Statement and Authorization: I understand that I am submitting personal health information to Nestlé HealthCare Nutrition for purposes applying to their Patient Assistance Program, and authorize Nestlé to use, maintain and share this information with affiliates and third parties to the extent necessary for evaluation of my application, shipment of any product provided under the Program, and regulatory product tracking requirements.

Please Note: All product determinations must be made by the responsible clinician.

Name (Please Print): ____

Relationship to Person Seeking Product: ____
(Self, Parent, Legal Guardian, Spouse, Relative or Caregiver)

Patient/Caregiver Signature: ______________________________ **Date:** ______________

Name of Patient	
Name of Person Receiving Shipment (if other than Patient)	
Street Address (Product cannot be shipped to a PO number or healthcare professional)	
City, State, Zip Code	
Email Address	
Phone Number	

Please FAX completed application to:	**Nestlé HealthCare Nutrition, Inc.** **FAX No: 1-480-379-5003**
OR MAIL to:	Nestlé HealthCare Nutrition, Inc. Attn: Renae Simmons 2150 E. Lake Cook Road, Suite 800 Buffalo Grove, IL 60089 (847) 808-5300

FOR INTERNAL USE ONLY

Approved _____ **Denied** _____ **Date:** ______________ **By:** ______________________