

INTRODUCTION:

We are currently offering a new program called Patient Assistance Program (PAP). This program was created to observe albumin levels in patients and to provide patients with financial assistance.

INSTRUCTIONS:

1. A Doctor, Dietitian or Social Worker will be able to choose up to 10 patients from each Hospital, Dialysis Center, Facility, etc.
2. Llorens Pharmaceutical will provide two bottles of Proteinex®, Proteinex®-100 or Proteinex®-18 Liquid 16oz, monthly of either Black Cherry or Lemon Lime or both for a period of three months.
3. Each bottle of Proteinex® will have a cost of \$8.95, shipping charges are included; both bottles will have a monthly cost of \$17.90.
4. You will need to fill out our Application before any exchange of product is made.
5. You may select up to ten patients for a period of three months.
6. After the three months are over, patient would be directed to a Supplier, Local Pharmacy or Llorens Home Delivery Store to be able to purchase the product.
7. Patient should pay preferably by credit card or they can pay by check before they receive the merchandise.
8. They can pay monthly or pay in full for the three months and will receive all 6 bottles at once.

QUESTIONS OR CONCERNS:

If you have any questions or concerns; please contact Giselle Rubiano.

- Call toll free: 1-866-595-5598
 - Giselle Rubiano
 - Extension: 108
 - E-mail: office@llorensparm.com

OTHER IMPORTANT INFORMATION:


- All application would be under review for a period of the minimum of five business days.
- NO RETURNS or REFUNDS!
- Terms, Condition & Pricing are subject to change.
- PRE-PAID PROGRAM!

We appreciate your attention and look forward to your support and endorsement.

Best Regards,

Giselle Rubiano
Llorens Pharmaceutical International Division, Inc
giselle@llorensparm.com

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Llorens Pharmaceutical International Division Patient Assistance Program Application (PAP)	Page 1 of 3
	For Llorens use only Request #: _____
 Llorens Pharmaceutical International Division Patient Assistance Program (PAP) P.O. Box 720008 • Miami, FL 33172 Phone 1-866-595-5598 Fax 305-716-5185	

Part I: INFORMATION FROM PHYSICIAN/REGISTERED DIETITIAN/SOCIAL WORKER (Only One Of The Above Required)

A. PHYSICIAN INFORMATION Please check circle to indicate change of address.

State License:		DEA#:	
Last Name:		First Name:	
Professional Designation:	Primary Specialty:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<i>Office Shipping</i> Address (No PO Box):			
City:	State:	Zip:	
<i>Office Mailing</i> Address:			
City:	State:	Zip:	
Office Contact:			
Phone:		Fax:	

B. NUTRITIONAL THERAPY INFORMATION

Product: Please check the appropriate box →	Proteinx®-18	Flavor: <input type="checkbox"/> Black Cherry <input type="checkbox"/> Lemon Lime
Amount needed per day: _____ Calories, Cans, or Grams (circle one)	_____% of Daily Calorie Intake Needs	Administration: _____ Oral _____ Tube

Please provide both a primary diagnosis (i.e. cancer, HIV/Aids, diabetes, etc) and the secondary condition (i.e. involuntary weight loss, cachexia, malnutrition, etc.) that requires the need for nutritional therapy.

Primary Diagnosis: _____

Secondary Conditions: _____

C. CERTIFICATIONS

- Authorization for Release of Health Information:** By signing this Application, I represent to Llorens that I have obtained all necessary Federal and state consents from my patient to allow me to release health information to Llorens Pharmaceutical International Division.
- Physician/ Care Coordinator Verification:** I verify that the information provided in this Application is current, complete and accurate to the best of my knowledge. If this applicant is eligible for the Llorens Pharmaceutical, I understand that Llorens will send the nutritional product to the applicant's home. Llorens reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice. By signing this form, I certify that the applicant is under my ongoing supervision for their nutritional therapy and that I am recommending the aforementioned nutritional product for the applicant. I understand that it is my responsibility to report any adverse events or conditions that may result from the use of the aforementioned nutritional product to Llorens Pharmaceutical. I acknowledge that I shall not seek reimbursement for any nutritional product provided hereunder from any government program or third-party insurer. I also understand that the applicant's acceptance into Llorens Pharmaceutical is not made in exchange for any explicit or implicit agreement or understanding that Llorens Pharmaceutical will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status.

Note: Physician may not delegate signature authority. (STAMPS NOT ACCEPTED)

Physician's Signature: _____	Date: _____
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Part II: APPLICANT INFORMATION

Note: Part II of the Application must be attested to by the applicant or applicant's representative. Patients in health care institutions are not eligible. **Applicant must have valid Social Security number to participate.**

A. CONTACT INFORMATION Please check circle to indicate change of address.


Social Security #:	Date of Birth:	Gender: <input type="radio"/> M <input type="radio"/> F
Last Name:	First Name:	Middle Initial:
Guardian Name:		
Address: (No Po Box):		
City:	State:	Zip Code:
Phone:		

B. HEALTH BENEFIT INFORMATION

Medicaid	Has applicant applied for financial assistance (Medicaid, SSI, etc)? <input type="radio"/> Yes <input type="radio"/> No	
	If yes	Has the applicant been denied assistance? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending <input type="radio"/> QMB <input type="radio"/> SLMB
	If yes	Provide copy of denial dated within 2 years.
	Does applicant have Medicaid coverage for nutritional therapy? <input type="radio"/> Yes <input type="radio"/> No	
	If no	Provide a copy of denial letter OR the published policy stating the nutrition therapy is not covered
	Is the applicant eligible for food stamps? <input type="radio"/> Yes <input type="radio"/> No	
Other State or Government	Does applicant have benefits through other state/government program (i.e., WIC, ADAP)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Applied <input type="radio"/> Application Pending <input type="radio"/> Waitlisted <input type="radio"/> Accepted <input type="radio"/> Denied	
	If yes	Does the benefit provide (partial or full) coverage for the requested product(s)? <input type="radio"/> Yes <input type="radio"/> No
		Program Name: _____ Amount Provided: _____
Private	Does applicant have benefits through private insurance/HMO? <input type="radio"/> Yes <input type="radio"/> No	
	If yes	Does the benefit provide (partial or full) coverage for the requested product(s)? <input type="radio"/> Yes <input type="radio"/> No
		Program Name: _____ Amount Provided: _____
	If no	Provide a copy of denial letter OR the published policy stating the nutrition therapy is not covered

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C. REPRESENTATIVE FOR PURPOSES OF PROGRAM

I permit the Llorens Pharmaceuticals International Division Patient Assistance Program to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:	
Name:	Relationship:
Name:	Relationship:

D. CERTIFICATION

In the event that I am eligible for the Llorens Pharmaceutical International Division Patient Assistance Program (PAP), I acknowledge that this assistance is temporary and I may be asked to reapply to designated intervals. I also understand that the Program may be changed or discontinued at any time. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I acknowledge that the Llorens Pharmaceutical International Division PAP may send me additional information about the Program, or information about alternate or additional financial assistance. I certify that the information I have provided in this Application is correct and complete.

- ✘ Payments will have to be made within the first 15 days.
- ✘ The product will be shipped directly to the facility and not to the patient’s home.

Applicant’s Signature:	Date:
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Note Applicant’s Representative: If the Applicant is unable to sign, or has designated signature authority, the Applicant’s Representative may sign this Application. However, only certain individuals may qualify as the Applicant’s Representative for purposes of this Application. An Application’s Representative must have the requisite knowledge and information regarding the Applicant’s financial and health care status to verify that all responses provided are accurate. An appropriate consent from the Applicant, attesting to the Representative’s possession of this knowledge or information must be on file if the Applicant’s Representative is someone other than a relative of the Applicant. A person or entity in the supply chain of the product to be received through the Program, including a health care provider or pharmacy receiving the free products, may not be named a Representative.

Signature of Applicant’s Representative:	Date:	Relationship:
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Note: If a consumer assistance or charitable organization, please list name of entity and purpose of entity under “Relationship”.

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