PATIENT ASSISTANCE PROGRAM

ELIGIBILITY REQUIREMENTS

Nestlé Health Care 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 has limited 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.

Please take note of the section of the application asking that you certify that:

- 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.

- 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.

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.

Thank you.

NestléHealthScience

2015 Patient Assistance Program

The Nestlé HealthCare Nutrition Patient Assistance Program is designed to meet needs of patients (i) who have special medically determined nutrient requirements which cannot be achieved by modification of the normal diet; (ii) whose sole or primary source of nutrition is the requested product; (iii) who do not have the financial resources or insurance to enable them to obtain medically necessary products; and (iv) who reside in the U.S.

How It Works:

- The only products available on the Program are those listed below. The products are primarily intended for tube feeding, however, some of them may be tolerated orally. All products are for consumption under the supervision of a medical professional.
- 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.
- You will be notified if your application is denied.
- If you are not notified of denial, the requested products will be delivered 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 patient will be notified if the application is incomplete or denied.

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

Step 1: Confirm Patient Eligibility

Estimated caloric need of patient (daily): _____ % caloric need to be met with requested product: _____

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**. Please do not send in this form unless this criterion is met).

☐ 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 unable to pay for or receive reimbursement by any third party payers, including any medical insurance or government healthcare programs, for the product(s) requested.

☐ 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®	Vanilla	9871616260
Peptamen® 1.5	Vanilla	9871618190
Peptamen® PreBio™	Vanilla	9871618185
Vivonex® RTF	Unflavored	362500
Vivonex® T.E.N.	Unflavored	071274
Vivonex® Plus	Unflavored	071298
Tolerex®	Unflavored	045805
GI Impaired Products for Pediatrics		
Peptamen Junior®	Vanilla	9871616252
Peptamen Junior® Fiber	Vanilla	9871660210
Peptamen Junior® PreBio™	Vanilla	9871616261
Vivonex® Pediatric	Unflavored	071310

Diabetic Products		
Diabetisource® AC	Unflavored	36500000
Glytrol	Vanilla	9871616275
Severe Wounds Products		
Impact Peptide® 1.5	Unflavored	4390097400
Standard Options		
Nutren® 1.5	Vanilla	9871616220
Nutren® 1.0 with Fiber	Vanilla	9871616056
Compleat®	Unflavored	140100
Standard Pediatric Products over age 1		
Nutren Junior®	Vanilla	9871616062
Nutren Junior® Fiber	Vanilla	9871616063
Compleat® Pediatric	Unflavored	142400

CONTINUE ON BACK OF FORM – SIGNATURES REQUIRED

Step 3: Healthcare Professional Information:

Name of Health Care Professional:	
Profession:	
Institution/Office:	
Address:	
Phone and Fax Numbers:	

Licensed Health Care Professional Signature: _____ **Date:** _____

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

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

☐ I am unable to pay for or receive any insurance reimbursement by any third parties for the product(s) requested.

☐ There will be no attempt to bill any third party, including without limitation, any federal or state healthcare program, for any products supplied.

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	
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:** _____