Patient Assistance Within Reach

Takeda Canine Assistance Program
P.O. Box 5727, Louisville, Kentucky 40255-0727
Phone: 1-800-830-9159   Fax: 1-800-497-0928

Thank you for your interest in the Takeda Shar-Pei Canine Assistance Program. Takeda offers dog owners in need an opportunity to receive their dog's Colcrys for free or at a low out-of-pocket cost.

HOW DO I APPLY?

1. Dog owners

Complete Sections 1, 2 and 3. You must sign Section 3.

- If you have no income, initial the Income Attestation line in Section 2.
- Fill out dog's first and last name on page 3.

VERY IMPORTANT: Attach copies of your financial documentation from last year. ***See Section 2 for details.*** Do not send originals, as they cannot be returned.

2. Veterinarians

Complete Sections 4 and 5 and fax the signed application with all your documentation to 1-800-497-0928 or mail it to the address above.

CAN I APPLY?

You are eligible to apply for the Takeda Canine Assistance Program if:

1. You are a legal resident of the United States.
2. You do not have prescription drug coverage for your dog's Colcrys medication.
3. You can provide your household's proof of income and are able to pay a reduced copayment (if applicable). See the Payment Calculator and Payment Method on pages 2 and 3.
4. Your veterinarian has prescribed Colcrys for your dog.

S P C A P P

IMPORTANT: Please go to next page.
Call 1-800-830-9159 if you need help.

Canine Assistance Program representatives are available Monday through Friday, 8:30 a.m. to 6:00 p.m. ET.

- Incomplete applications, missing documentation or neglecting to include your payment (if applicable) will delay the processing of your application.
- If the application is approved, the medicine will be shipped directly to the home address provided.
- You must send in your family's proof of income to be considered for this program.

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

SECTION 1: DOG AND OWNER INFORMATION

First Name	Last Name	Home Address	
City	State	ZIP Code	Preferred Daytime Phone Number
U.S. Resident ☐ Yes ☐ No	Dog's Name		Dog's DOB

SECTION 2: INSURANCE AND INCOME

Do you have prescription drug coverage for your dog's Colcrys medication?
☐ Yes ☐ No

Number of people in household

Total *yearly* household income: $__________________

IMPORTANT: You must send in your family's proof of income to be considered for this program. The following are acceptable forms of income documentation for you and anyone in your family:

- Copies of the last two pay stubs
- A copy of last year's federal income tax return
- A copy of the most recent Social Security Disability award letter, benefits statement or monthly check

INCOME ATTESTATION

☐ My family has zero income and therefore I will not be able to submit proof of income. (Initial this box only if the family has zero income.)

SECTION 3: DOG OWNER ATTESTATION

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW

By signing this form, I am saying that all the information I am giving is true, complete and accurate, that I cannot afford the prescribed Colcrys for my dog, that I have no pet insurance that pays for this medication and that, if qualified for the program, I understand that the medication will be used solely for my dog.

I understand that this information is confidential and will be used only by Takeda and its contractors to qualify my dog for this program. I understand that Colcrys is not approved by the FDA for use in animals.

Dog Owner Signature *(Stamped Signatures NOT ALLOWED)* X	Date

SP CAPP

PAYMENT CALCULATOR AND PAYMENT METHOD

Select your household size from the first column. Household size equals you, your spouse, and your dependents. Go across the row until you find your household income level. If your income is more than the income listed in the last column, you may not qualify at this time.

Household size	30-day supply is free if yearly income is less than*:	30-day supply reduced price of $5 if yearly income is**:	30-day supply reduced price of $25 if yearly income is***:	You may not qualify if yearly income is more than:
1	$33,510	$33,511–$ 44,680	$44,681–$67,020	$67,020
2	$45,390	$45,391–$ 60,520	$60,521–$90,780	$90,780
3	$57,270	$57,271–$ 76,360	$76,361–$114,540	$114,540
4	$69,150	$69,151–$ 92,200	$92,201–$138,300	$138,300
5	$81,030	$81,031–$108,040	$108,041–$162,060	$162,060

*60-day and 90-day supplies are also available at no cost **60-day supply payment is $10, 90-day supply payment is $15 ***60-day supply payment is $50, 90-day supply payment is $75

PLEASE PRINT CLEARLY IN BLACK OR BLUE INK

*Dog's First and Last Name:*______________________________

If you are not required to make a payment, leave this section blank. If you anticipate qualifying for a reduced price, complete the following:

☐ **Credit card** | ☐ Enclose check or money order payable to **AmeriCares**

Name as it appears on credit card ____________________

Billing Address *(If different from your address on page one)*

____

____

Amount Paid ____________________

Expiration Date: Month __ __ Year __ __

Security Code *(on back of card)* __ __ __

Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Cardholder Signature X	Date

SECTION 4: VETERINARIAN INFORMATION

Last Name	First Name	Clinic Name (if applicable)		
Address		City	State	ZIP Code
State License Number		Phone	Fax	
List all current patient medications below:		Is patient allergic to any medications? ☐ YES *(please list below)* ☐ NO		

S P C A P P

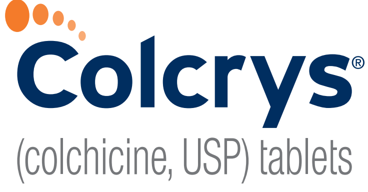
SECTION 5: PRESCRIPTION INFORMATION

Dog's Diagnosis: ☐ Shar-Pei Fever

MEDICATION	DIRECTIONS	QUANTITY	DAYS SUPPLY	REFILLS
COLCRYS 0.6-mg tablet			_____days	

My signature certifies that if the product is sent to my office on behalf of the patient, I understand that it must be used for the patient listed on this application, and not be resold or offered for sale or trade, nor shall the patient nor any third-party payer, Medicare or Medicaid be charged for this product. I verify that, to the best of my knowledge, this applicant is in need of assistance.

Veterinarian Signature *(Stamped Signatures NOT ACCEPTED)* X	Date



Have your veterinarian's office fax to:
1-800-497-0928

Mail your complete application and other papers to:
TAKEDA CANINE ASSISTANCE PROGRAM
P.O. Box 5727, Louisville, Kentucky 40255-0727

COLCRYS is a trademark of Takeda Pharmaceuticals U.S.A., Inc., registered with the U.S. Patent and Trademark Office and used under license by Takeda Pharmaceuticals America, Inc.
This program, as well as all Takeda Pharmaceuticals America, Inc. programs, can be discontinued or changed at any time without notice at the discretion of Takeda Pharmaceuticals America, Inc.

© 2012 Takeda Pharmaceuticals America, Inc. 10/12