PANCRECARB®
(pancrelipase)
Delayed-Release Capsules – Bicarbonate-Buffered and Enteric-Coated Microspheres

Assistance Program℠
Enrollment Form

PANCRECARB® Assistance Program℠

This program is available for patients with financial difficulties. Physicians apply for this program on behalf of their patients. Eligibility is determined on a case-by-case basis through a formal review process at Digestive Care, Inc. Upon approval, a *FREE* three month supply of PANCRECARB® will be sent to the requesting physician for distribution to their patient. If another supply is needed the physician is to submit another enrollment form.

Fax this Enrollment Form to ***Digestive Care, Inc.*** *at:* **Fax 610-882-0349**

Date of Request: _ _ - _ _ - _ _ _ _
Month Day Year

Physician Information:

Physician Name: ______________________ Specialty: ______________
Center Name: ______________________ Phone: ______________
Center Address: ______________________ Fax: ______________
City: ______________________ State: ________ Zip: ______________

Product Requested: ☐ ***PANCRECARB® MS-4*** ☐ ***PANCRECARB® MS-8*** ☐ ***PANCRECARB® MS-16***

Caps per Day: __________ Caps per Meal: __________ Caps per Snack: __________
Sig: ______________________
Physician's Signature: ______________________ DEA#: ______________

Patient Information:

Patient Name: ______________________
Date of Birth: _ _ - _ _ - _ _ _ _ Patient's Age: ________ Weight: ________ Height: ________
Insurance Information: ______________________
Reason for Request: ______________________

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Patients participating in Medicare, Medicaid or any other State or Federal Subsidized Pharmacy Benefit Program are not eligible for this program.

Consent and Authorization Agreement

I hereby authorize Digestive Care, Inc., (DCI) to enroll the above-named patient in the PANCRECARB® Assistance Program℠. I understand the enrollment in the PANCRECARB® Assistance Program℠ will qualify the patient to receive a three month supply of PANCRECARB® free of charge. Promptly after this enrollment form is received, DCI will send a free three month supply of PANCRECARB® to the requesting physician. The free product will be labeled with the Patient's name and sent to the physician for distribution to the patient. DCI will maintain the confidentiality of patient information with appropriate safeguards as required by law and by the physician's privacy practices. DCI may use patient information for marketing purposes. DCI reserves the right to withdraw or cancel this offer at any time without notice. The PANCRECARB® Assistance Program℠ is subject to availability of products and does not constitute an entitlement.

Patient Name (please print): ______________________
Patient Signature: ______________________
IF PATIENT IS A MINOR:
Parent/Guardian/Guarantor Name: (please print) ______________________
Patient/Guardian/Guarantor Signature: ______________________ Date: __________

1120 Win Drive
Bethlehem, PA 18017-7059
Voice: 610-882-5950
Fax: 610-882-0349
www.DigestiveCare.com

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