Radiant Health Centers
Compassionate Care for All

Manufacturers Patient Assistance Program (MPAP) Eligibility Form

(To be used when client is requesting assistance for a medication on a repeated basis)

Dear Physician,

Your client is requesting assistance under the Emergency Assistance for Medications Program which helps people obtain medication that they otherwise would not be able to afford. For any client who is requesting repeated assistance for a specific medication (more than a one month supply of a medication), proof must be provided that their physician has attempted to enroll the client in the Manufacturer's Patient Assistance Program (MPAP), if one exists.

The Emergency Assistance for Medications Program is funded through Ryan White funds and may only be used as a payer of last resort. Medications for chronic use will be approved for one month only without a completed MPAP form. Documentation of the attempt to enroll the client into the MPAP will be required for any future request of the medication listed below.

For your convenience, we have developed this form to assist you in this process. **Please return this form, once completed, to the client's assigned case manager who is listed below.**

_ _ _ _ _ _ _ _ _ _ _ _

Client Name: _____

Assigned Case Manager/Agency: _____
Fax:_____

Medication that client is seeking assistance for: _____
(Please only one medication per form)

Check off one of the items below:

___ I have researched the availability of an MPAP for the above medication and have been notified that no such program exists.

___ I have assisted the client to enroll in the MPAP that is available for this medication but have not received notification yet regarding whether client has been accepted.

___I have assisted the client to enroll for the MPAP that is available for this medication and have received notification that client was denied access to the program.

As the client's physician it is my assessment that the client will need the requested medication for more than one month.

_____ _____ _____
Signature of Physician Physician Phone Number Date