MEDICATION ASSISTANCE & SUPPORT SERVICES

PROGRAM APPLICATION

Program Details and Application Instructions

The Diabetes Foundation (DFI) assists uninsured and underinsured New Jersey residents who are unable to pay for diabetes medications and/or supplies due to financial hardship. DFI's Medication Assistance Program is an, emergency service that will be provided for up to eight weeks to bridge the gap until a long-term solution can be obtained. DFI also maintains a toll-free support network, which is available to medication recipients and others who may have questions or need ongoing resources for obtaining prescriptions, medical care, daily diabetes management, and more.

ALL APPLICATIONS REQUIRE THE FOLLOWING:

- Forms must be submitted by a "Referrer" who can confirm the applicant's financial need (i.e. physician, nurse, social worker, case worker).
- Forms received directly from applicants will not be accepted.
- A document displaying proof of address (i.e. copy of driver's license, utility bill, phone bill, invoice etc.). Applicants must be residents of the state of New Jersey in order to receive assistance.
- Prescriptions for each item requested- copies are acceptable, however those who have a Medicare plan are required to submit original scripts at time of referral or via mail afterwards. Please include prescriptions for all testing supplies, including glucometer, test strips, and lancets, as well as any medications including dosing and medication supplies.
- Copies of both sides of the applicant's insurance card(s) if they currently possess private/employer insurance, Affordable Care Act insurance, Medicare, Medicaid etc. (NOTE: This does not disqualify the applicant from the program)

Incomplete applications will be held until all required documents have been provided

Each application will be reviewed on a case-by-case basis so that DFI can determine the most effective way to assist the applicant for the short-term, as well as the long-term. **In some situations, applicants may be deemed as better qualified to speak directly with support professionals in lieu of receiving medications first.**

Once approved, prescriptions are delivered or shipped directly to the applicant by our partner pharmacy within 2-3 business days. Shipments can also be sent to the medical facility of choice, if preferred. Please contact our office if the applicant has an emergency situation and will need their prescription delivery expedited, where a minimum of 24 hours should be allowed. We will try our best to accommodate all special requests.

THIS PROGRAM PROVIDES THE FOLLOWING MEDICATIONS & SUPPLIES:

Please request items from the following list only. Others may be provided on a case-by-case basis, when possible. If our organization cannot provide a certain item, we may be able to help to obtain it from another source. Please contact us.

Please Note: Rush orders, or orders for people who possess private insurance, ACA insurance, or Medicare may require pickup at a specific pharmacy.

Insulin Vials & Pens:

- Apidra - Vial & Solostar Pen
- Humalog/Humalog Mix 75/25- Vial, QwikPen or HumaPen Luxura Cartridge
- Novolog/Novolog Mix 70/30-Vial, FlexPen/FlexTouch, or NovoPen Jr. Cartridge
- Humulin N, R or 70/30
- **Novolin N, R or 70/30** *(Most Preferred Insulin ; Vial)*
- Lantus- Vial or Solostar Pen
- Levemir- Vial or FlexPen/FlexTouch
- Basaglar KwikPen
- Toujeo Solostar Pen

Oral Agents:

- Pioglitazone (Generic for Actos)
- Nateglinide (Generic for Starlix)
- Repaglinide (Generic for Prandin)

Insulin Syringes/Pen Needles:
(Please indicate sizes on prescriptions)

- BD Syringes-1cc, 0.5cc or 0.3cc
- BD Ultra-Fine Pen Needles

Testing and Other Supplies:

- Glucometer (Arkray Glucocard or ReliOn brand)
- Test Strips (brands listed above)
- Lancets/Lancing Device
- Glucagon Emergency Kit (Qty: 1 Only)- For type 1 children or adult extenuating circumstances
- Ketostix – For type 1 children or pregnant women/GES

NOTE: If generic oral medications are required, please refer applicants to a retail pharmacy such as ShopRite or a website such as Blink Health that offers FREE tablets (Metformin, Glyburide, Glipizide, Glimiperide, Pioglitazone) in order to conserve DFI funds for other necessary medications. If the applicant is unable to obtain the medication in this manner, we will evaluate the prescriptions on a case-by-case basis.

PRESCRIPTION RECOMMENDATIONS

In an effort to help the DFI provide assistance in an affordable manner:
Please consider using the most affordable brands of insulin, supplies, and testing products. This will also benefit applicants who will not qualify for long-term assistance programs and will be cash-paying once they finish their initial supply of prescriptions from the Foundation.

Affordable brands include, but are not limited to:

- Novolin insulin (WalMart, CVS, and other local pharmacies)
- Arkray Glucocard Vital testing supplies (ShopRite and other local pharmacies)
- ReliOn testing supplies (WalMart)

FOR INSULIN USERS: In some cases, insulin vials are more cost-effective than insulin pens, and in others, the opposite is true. DFI will do our best to provide the option that yields the largest supply of insulin for the applicant unless they are not able to be trained to use that product.

APPLICATION FOR

MEDICATION ASSISTANCE & SUPPORT SERVICES

DATE OF APPLICATION: ______________________________

I. APPLICANT CONTACT & DEMOGRAPHIC INFORMATION

Applicant's Name: ____

Gender: ☐ Male ☐ Female ☐ Prefer Not To Answer

Primary Address: ____ Apt. #:___________

City: _______________________________State: __________ Zip: _______ County:________________

Date of Birth: ____________/____________/_____________ Age: ______________________________

Cell Phone: __________-__________-_________

Home Phone: ________-_________-__________

Email Address: ____

How Long Have You Lived in New Jersey?: __________________

Do You Live Alone? ☐ YES ☐ NO

*****Please attach proof of residency/address confirmation*****

Are You A Veteran?: ☐ YES ☐ NO

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________________________________

If applicant does not speak English, is there someone else we may contact about their application?

Name/Relationship: ____________________________________

Phone: _______-_______-_________

Race/Ethnicity:

☐ African American ☐ Pacific Islander ☐ Caucasian ☐ American Indian or Alaskan Native

☐ Asian ☐ Hispanic ☐ Latino ☐ Other ___________________________

Citizenship:

Citizenship status does not disqualify eligibility from our program; however, it allows us to better assist you in finding long-term assistance. Please check one of the following:

☐ US Citizen ☐ Permanent Resident ☐ Other _____________________

II. REFERRER INFORMATION

Referring party must represent a medical or social services organization and must attest to the applicant's financial need.

Name: ____ Job Title: ______________________________

Professional Type: ☐ Social Worker ☐ CDE ☐ RN/APN ☐ Physician ☐ Other _____________________

Facility Name: ____

Department and Address:____

Telephone: __________- ___________ - ____________ Fax: _________-__________-___________

Email Address: ____

Will you be assisting the applicant in securing long-term/permanent medication assistance?

☐ YES ☐ NO

IF NO, will the applicant be referred to another agency or program for further assistance?

Please state where: ____

III. APPLICANT MEDICAL INFORMATION & PRESCRIPTION DATA

Please check diabetes type that best describes the applicant:

☐ Prediabetes ☐ Type 1 ☐ Type 2 ☐ Gestational #_______weeks pregnant

Most Recent Hemoglobin A1c: ____________

Age of Diagnosis: _________ Applicant's Height: ___________ Applicant's Weight: ____________

Allergies to Medications: ☐ Yes ☐ No

If Yes, please list: ____

Other medical conditions, diagnoses, recent procedures, etc.:

____

____

____

Please list all prescribed medications and supplies that you are requesting for the applicant.
This section should match the prescriptions provided.
Please be mindful of using more affordable medications and supplies when appropriate.
****Note: Prescriptions are required for all items, including needles and testing supplies.**

	YES	NO	NAME OF PRESCRIPTION/DOSAGE/FREQUENCY
Insulin ☐ **Vials** ☐ **Pens**			Brand/Dosage: ___________________________________ We may need to interchangeably substitute pens or vials based on dosing. Is this acceptable? __________________
Syringes			Syringe Size: ____________________
Pen Needles			Needle Size: _____________________
Test Strips			Tests ______ times per day
Lancets			
Glucometer/ Lancing Device			*Patient will receive Glucocard Vital unless otherwise noted
Oral Medications			
Glucagon Emergency Kit (Children Only)			
Other Medications/Supplies			

Where would you like prescriptions delivered?: ☐ Applicant's Home ☐ Medical Facility/Other

(Please list address and contact person/dept. if other than Home)

____

____

IV. NARRATIVE

Use the space below to explain the applicant's circumstances. Why is (s)he requesting assistance?

____

____

____

____

____

V. FOLLOW-UP INFORMATION

Please indicate applicant's status for the following programs. Submitting applications for short-term assistance from the DFI and longer-term assistance simultaneously ensures that the applicant will never be without their diabetes medication and supplies.

	Approved/Current Holder	Does Not Qualify	Application Denied	Application Pending	(If Pending) Date Submitted
MEDICAID	☐	☐	☐	☐	☐
PAAD OR SENIOR GOLD	☐	☐	☐	☐	☐
MEDICARE Currently Hold Which Part(s)?_______________	☐	☐	☐	☐	☐
VETERAN (VA) COVERAGE	☐	☐	☐	☐	☐
PHARMACEUTICAL COMPANY PATIENT ASSISTANCE Company Name(s): ______________________________ ______________________________	☐	☐	☐	☐	☐
OTHER (340b at FQHC, Private Insurance etc.): ______________________________ ______________________________	☐	☐	☐	☐	☐

IF APPLICANT HAS SOME TYPE OF INSURANCE/PRESCRIPTION COVERAGE, PLEASE LIST THE FOLLOWING DETAILS (Note: This will not disqualify eligibility from the program. **Copies of both sides of the applicant's insurance card(s) must also be included.)

PLAN ID #__________________________________ GROUP #___________________________________

RX BIN #___________________________________ RX PCN #__________________________________

MEDICARE CLAIM #____

INSURANCE CARRIER/HMO____

-OR- The applicant does not qualify for any of the above programs because:

____

____

____

____

VI. PHYSICIAN INFORMATION

Name of Physician/Practitioner Writing Prescriptions: ____

Facility Name/Dept.: ____

City: ____ State: ________________________________

Will this physician/practitioner be the primary treating physician? □ YES □ NO

If NO, please indicate which physician/clinic will be providing ongoing medical treatment:

Name of Physician/Practitioner and/or Clinic: ____

City: ____ State: ________________________________

VI. REFERRER CERTIFICATION

I (referrer's name) __________________________________ certify that the applicant being referred is in financial need and will truly benefit from the medication assistance program. I have explained that the program is a short-term supply of diabetes medications and supplies, and cannot be renewed or refilled. I also certify that I have sent applications or provided information for long-term assistance to the programs indicated in Section V, unless otherwise stated.

____ ___________________________

Signature of Referrer Date

VII. EXPLANATION OF PROGRAM AND APPLICANT CERTIFICATION

I (applicant's full name) ________________________________ verify that the information provided on this application is true and accurate. I authorize the Diabetes Foundation to use this information to assess my eligibility for participation in the medical assistance program. I understand that this assistance will provide up to eight weeks of medications and supplies for one time only. I certify that I do not have the ability to pay for medications at this time and that I am in the process of applying to programs for which I may be eligible for assistance. I understand that it is at the discretion of the Diabetes Foundation, Inc. that each application is approved. I authorize the Diabetes Foundation, Inc. to contact me, or my health care professional, to follow up on my progress. I give permission to my health care professional to disclose my personal information, including protected health information, to the Diabetes Foundation,

Inc. as it relates to this request. I understand that the Diabetes Foundation, Inc. may redisclose my confidential information for the purposes of this program. I acknowledge that the Diabetes Foundation, Inc. is not specifically bound by the Health Insurance Portability and Accountability Act or the regulations communicated thereunder, but that the Foundation makes reasonable efforts to protect my confidential information and comply with all applicable federal and state laws.

______________________________________ _______________________

Signature of Applicant Date

Applications and Prescriptions Can Be Submitted Via:
Fax: (201) 444-5580 | Email: info@diabetesfoundationinc.org
Mail: Diabetes Foundation, Inc.
411 Hackensack Avenue, Floor 7
Hackensack, NJ 07601
Questions? Phone: (201) 444-0337 Web: www.diabetesfoundationinc.org