



**Anadrol® Assistance Program**  
**P.O. Box 4008 - Clinton, NJ 08809**  
**Phone: 800-593-7923 - Fax: 732-507-7624**  
**Email: [alaven@rxhope.com](mailto:alaven@rxhope.com)**

**Physicians can apply online at [www.RxHope.com](http://www.RxHope.com)**

**PHYSICIAN INFORMATION**

Physician Name (Last, First, MI) \_\_\_\_\_ Designation \_\_\_\_\_

DEA # (Required)\* \_\_\_\_\_ State License # \_\_\_\_\_ Exp \_\_\_\_\_

DEA Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Contact \_\_\_\_\_

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that the medication prescribed shall be sent to my office for dispensing to this patient, and I certify that the medication requested shall be used to treat this patient and I shall not seek reimbursement for this medication from any third party.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Medication must be shipped to DEA Address**

**PRODUCT INFORMATION**



Indicate number of tablets per day:

\_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3

**\*PLEASE ATTACH PRESCRIPTION\***

■ 50mg tablets (100 tablets per bottle)

■ A 30-day supply is provided

Number of Refills: \_\_\_\_\_

**PATIENT INFORMATION**

Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status: S M D W Other

Telephone \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Sex: M / F

Social Security # \_\_\_\_\_ Are you a U.S. Resident? Y / N Are you a Veteran? Y / N

Number of Persons in Household \_\_\_\_\_ Adjusted Gross Income\* (Line #37 on 1040) \$ \_\_\_\_\_

**\*Attach proof of income (Most recent U.S. Income Tax Return, IRS Form 1040, Social Security/Disability Award letter, Benefit Statement or monthly check**

Are you enrolled in Medicare, Medicaid or Medicare Part D? \_\_\_\_\_

*If yes, please specify*

I certify that the information is complete and accurate to the best of my knowledge, and that I am eligible to receive the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential, except as otherwise required by law. I certify that I shall not seek reimbursement for any medication dispensed as part of the program. I hereby authorize the patient assistance program to obtain and disclose information from physicians, insurance companies and other information as necessary to verify the information provided in this application.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Fax completed application to 732-507-7624 or Mail to the address above**