In order to qualify for Medication Assistance:

Please complete the following documents and return along with the requested documents to our office in the envelope provided or fax to:

Michigan Parkinson Foundation
30400 Telegraph Road Suite 150
Bingham Farms, MI 48025

Phone: 248-433-1011
Fax: 248-433-1150

Once all forms are received by Michigan Parkinson Foundation Staff, eligibility will be determined and you will be notified as soon as possible.

Medication Assistance Program

Genoa Pharmacy
Phone: 586-323-8270 Fax: 586-323-8273 Contact person: Pharmacy

Patient Information **Date:**_____

Patient Name:_____
Contact/Caregiver Name (if applicable):_____
Address:_____
City:_____State:_____Zip:_____
Phone(_____)_____ Patient's Date of Birth:_____

Financial Information:

1. Monthly cost of PD meds: $_____ Cost of other meds: $_____
   Monthly/annual cost for health care: $_____
   Monthly cost for health care for other immediate family members: $_____
2. Do you have health insurance: Yes:_____ No:_____
   Name of insurance company:_____
   Do you have prescription coverage? Yes___ No___
   Family member health insurance coverage? Yes__ No___
   Rx: Yes___No___
3. Pharmacy Name:_____ Phone:(_____)_____
4. Physician Name:_____ Phone:(_____)_____

Refills/prescription # of bottle:_____
Allergies:_____
Ever order through Advanced Care Pharmacy Services or Genoa? Yes___ No___

By signing this document I agree that all information provided above is true and accurate to my knowledge and consent.
Patient Signature:_____ Date:_____

Parkinson's Medications:

Immediate-Release carbidopa-levodopa (Sinemet)
____ 10/100 ___25/100 ____25/250 x___/day = ____tablets

Generic carbidopa-levodopa
____ 10/100 ___25/100 ____25/250 x___/day = ____tablets

Sustained-Release carbidopa-levodopa (Sinemet CR)
____ 25/100 ___50/200 x___/day = ____tablets

Stalevo (approved RX by MPF on 08-28-14) ___strength x___/day = ____tablets

Trihexyphenidyl (Artane)
____ 2 mg ___5 mg x___/day = ____tablets

Benztropine (Cogentin)
____ 0.5 mg ___1 mg ___2 mg x___/day = ____tablets

Selegiline (Eldepryl) ___5 mg x___/day = ____tablets

Parlodel (Bromocriptine)
____2.5 mg ___5 mg x___/day = ____tablets

Amantadine (Symmetrel) ___ 100 mg x___/day = ____tablets

Pramipexole (Mirapex) ___ strength x___/day = ____tablets

Ropinirole (Requip) ___ strength x___/day = ____tablets

Entacapone (Comtan) ___ strength x___/day = ____tablets

Tolcapone (Tasmar) ___ strength x___/day = ____tablets

Quetiapine (Seroquel) ___strength x___/day = ____ tablets

Midodrine ___strength x___/day = ____ tablets

Droxidopa ___strength x___/day = ____ tablets

Rotigotine (Neupro) ___strength x___/day = ____ tablets

Rasagiline (Azilect) ___strength x___/day = ____ tablets

Rytary ___strength x___/day = ____ tablets

MPF Staff Signature:_____ **Date:**_____

By signing this document I agree that all information provided above is true and accurate to my knowledge and consent.

Patient Signature:_____ Date:_____

MICHIGAN PARKINSON FOUNDATION
MEDICATION ASSISTANCE PROGRAM
INVOICE

Date:_____

Patient Name/DOB	Medication	Date RX filled	Amount

Signed:_____

_____
Print (Name)

Please submit payment to:
Genoa 20098 Shelby
PO 1450 Lockbox NW 6247
Minneapolis, MN 55480
……

By signing this document I agree that all information provided above is true and accurate to my knowledge and consent.

Patient Signature:_____ Date:_____