NewYork-Presbyterian
Ambulatory Care Network

Pharmacy Assistance Program
622 West 168th Street
VC 10, Area C, Room 3
New York, N.Y. 10032
Tel: (212) 342-1617
Fax: (212) 342-1792

PROVIDER POWER OF ATTORNEY

I, ________________________________, physician employed at ___________________located at________________________ ____ (the "Health Center") hereby appoint Alfredo Jones, solely in his capacity as Program Coordinator of Salud A Su Alcance Pharmacy Assistance Program ("ACN-PAP") at New York Presbyterian Hospital ("NYP"), 622 West 168th Street, New York NY 10032, as my Attorney-in-Fact ("Agent").

The purpose of designating the patient assistance program (PAP) advocate named above as my Agent to sign the PAP applications on my behalf is to expedite the process of PAP applications and reduce the wait time for my patients to access their donated medications.

My Agent shall have restricted authority to act on my behalf only to assist my patients with prescriptions that I prescribed to be processed for Patient Assistance Programs offered by various pharmaceutical companies. My Agent's powers shall include the power to:

1. Obtain the necessary information and documentations from my staff or my patient to complete PAP applications for prescriptions authorized by me.

2. Sign PAP application on my behalf for all participating pharmaceutical companies attesting to the accuracy of the information provided on the application.(Appendix I)

3. Sign Letters of Hardship to be sent to participating pharmaceutical companies when necessary (Appendix II)

Any power or authority granted to my Agent under this document shall be limited to patients under my care at the Health Center who wish to access donated prescription medications through NYP's ACN-PAP program.

I authorize my Agent to indemnify and hold harmless any third party who accepts and acts under this document.

My Agent shall not be entitled to reasonable compensation for any services provided as my Agent. My Agent shall not be entitled to reimbursement of all reasonable expenses incurred in connection with this Power of Attorney.

My Agent shall provide an accounting for all prescriptions handled and all forms signed as my Agent, if I so request or if any authorized representative or provider acting on my behalf makes such a request.

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This Power of Attorney shall become effective immediately and shall continue effective until written notice of my participation in Ambulatory Care Network-Pharmacy Assistance Program is revoked.

Dated ____________________, 200__ at _________________________,
_________________________.

__________________________________ DEA# ___________
Physician Signature LIC# ____________

Physician full legal name: ______________________________

____
Witness Signature

Witness full legal name: ________________________

____
Witness Signature

Witness full legal name: __________________________

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Appendix I.

Examples of statements from patient assistance applications that Agent would sign on behalf of the provider.

Example 1:
I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the PHARMA CO. and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. I understand that PHARMA CO. reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from PHARMA CO. will not be resold nor offered for sale, trade or barter and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge.
Healthcare Provider Signature:_________________________ Date:________________________

Example 2:
By signing below, you the healthcare provider understand and agree that:
• Any medications supplied by Pharma Co. as a result of this order form are for the use of the patient named on this form only, and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid or other benefit provider) for reimbursement.
• Pharma Co. may contact the patient directly to confirm receipt of medications.
• Pharma Co. may change or cancel this program at any time.

Original signature of practitioner: __________________________ Date: __________________

Example 3:
Prescriber Certification By my signature, I certify that the use of the indicated pharmaceutical product(s) is medically necessary. I have no knowledge of any intent to sell, barter or give this product to any person other than the patient for whom it has been prescribed. To the best of my knowledge, the patient has no medical/prescription insurance benefits for the indicated pharmaceutical(s), including Medicaid or other public programs other than as indicated, and the patient has insufficient financial resources to pay for the prescribed therapy.

____

Prescriber's signature Date
(Original signature required. Stamped signature not accepted)

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Appendix II.

Provider's
First Name, Last Name, MD

16 E 16th St.
NY, NY 10003
(212) XXX-XXXX

Today's Date

Re: Patient's First Name Last Name

Dear Pharma. Co.,

The above referenced applicant is in my care. At the moment the patient is receiving assistance via generous donations from friends and family. The applicant currently has no reportable income. After having screened him/her, we are certain that he/she is eligible for the patient assistance program. Thank you for considering his/her enrollment application.

Respectfully,

Physician, M.D.
DEA# XX1234567
LIC# 123456

ACN-PAP can only process prescriptions written by physicians on NYPH's medical staff