Medication Assistance Program Application

APPLICANT INFORMATION – PLEASE PRINT

Name: _____ _____ _____
Last First Client I.D. Male or Female

Mailing Address: _____ _____ _____
(Must be a street address) Telephone Date of Birth

_____ _____ _____ _____
City County State Zip

I am presently living in Florida. _____ Yes _____ No

I have diabetes and require insulin. (prescription attached.) _____ Yes _____ No

I have epilepsy and require medication. (prescription attached.) _____ Yes _____ No

I do not have Medicaid or health insurance that covers prescription medication, or I have an insurance co-pay or deductible I cannot afford. _____ Yes _____ No

My annual net family income is $_____

There are _____people in my family.

My assets, other than my homestead, are below $2,500. _____ Yes _____ No

MEDICAL INFORMATION

Do you have any known allergies/drug reactions? _____ Yes _____No
If yes, please name the drug(s):

_____
_____
_____

Do you use any medical devices to administer or monitor your medical condition? _____ Yes _____No

If yes, please name the medical device(s):

_____
_____
_____

List prescription medications you are now taking which were not received from Central Pharmacy:

_____
_____
_____

List Over-the-Counter medications you are now taking:

_____
_____
_____

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Please check if you have any of the health conditions listed below:

_____Arthritis
_____Ulcers
_____Diabetes
_____Cancer
_____Epilepsy
_____Asthma
_____Heart Conditions
_____Kidney Disease
_____Lung Disease
_____Rheumatic Fever
_____Tuberculosis
_____Liver Disease
_____Blood Clotting Disorders
_____High Blood Pressure
_____Parkinson's Disease
_____Anemia
_____Pregnancy
_____Other _____

I acknowledge that all information provided by me is true to the best of my knowledge. I understand if I have a change in income or assets, I must report that change to the county health department (CHD) within 90 days of that change. I understand that the CHD may verify the income information I provide. I understand that any intentional false or misleading statement by me can be charged as a second degree misdemeanor and will result in my loss of eligibility for this program.

Please mail my prescription to: _____ my home address above or _____ the CHD at _____

_____ _____ _____

Applicant Signature **Date**

EPILEPSY ELIGIBILITY DETERMINATION: TO BE COMPLETED BY CHD – CHECK THE APPLICABLE BOX BELOW

I certify that based on the information provided by the applicant and according to IOP 320-08, this applicant

☐ is eligible for the Epilepsy Medication Program.

☐ is eligible for the Epilepsy Medication Program as a current client with an annual net family income at 101% to 200% of the Federal poverty guidelines, that meets all of the other eligibility criteria, has no resources to purchase epilepsy medication and no other source can be found for his/her epilepsy medication. This client shall be charged a fee for the epilepsy medication based on a sliding fee scale as set forth in Chapter 64F-16, F.A.C.

☐ is not eligible for the Epilepsy Medication Program.

Signature of CHD Employee	Date of Eligibility Determination	Date of Eligibility Expiration (one year from determination date)

EMERGENCY ISSUANCE: TO BE COMPLETED BY CHD

This applicant is not eligible for the Epilepsy Service Program but has declared that he/she does not have the resources to purchase epilepsy medication. No other source can be found for his/her epilepsy medication; therefore this applicant is eligible to receive a one-month emergency supply of epilepsy medication at no cost, one time within a 12-month period.

Signature of CHD Employee	Date

REFERRAL TO THE EPILEPSY SERVICE PROGRAM

CHD staff are encouraged to use the opportunity presented while determining eligibility for the epilepsy medication program to ask the client if he/she has signed up for the Epilepsy Service Program (ESP). If the client is not an ESP client, CHD staff should provide the client with information on the Epilepsy Service Program that is available in the county. This information can be obtained on the last page of this form.

INSULIN DISTRIBUTION PROGRAM ELIGIBILITY DETERMINATION: TO BE COMPLETED BY CHD – CHECK THE APPLICABLE BOX BELOW

I certify that based on the information provided by the applicant and according to Chapter 64F-18, F.A.C., this applicant

☐ is eligible for the Insulin Distribution Program.

☐ is eligible for the Insulin Distribution Program as a current client with an annual net family income at 101% to 200% of the Federal poverty guidelines, that meets all of the other eligibility criteria, has no resources to purchase insulin, and no other source can be found for his/her insulin. This client shall be charged a fee for the insulin based on a sliding fee scale as set forth in Chapter 64F-16, F.A.C.

☐ is not eligible for the Insulin Distribution Program.

Signature of CHD Employee	Date of Eligibility Determination	Date of Eligibility Expiration (one year from determination date)

EMERGENCY ISSUANCE: TO BE COMPLETED BY CHD

This applicant is not eligible for the Diabetes Insulin Distribution Program but has declared that he/she does not have the resources to purchase epilepsy medication. No other source can be found for his/her epilepsy medication; therefore this applicant is eligible to receive a one-month emergency supply of epilepsy medication at no cost, one time within a 12-month period.

Signature of CHD Employee	Date

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES) CLIENT REMINDER

CHD staff are encouraged to use the opportunity presented while determining eligibility for the Insulin Distribution Program to ask the client if he/she has attended a DSME class. If the client has not attended a class, CHD staff should provide the client with information on classes available in or near the county. This information can be obtained at Find an Accredited Diabetes Education Program (adces.org) or Find a Diabetes Education Program | American Diabetes Association.

INSTRUCTIONS TO COMPLETE THE MEDICATION PROGRAM APPLICATION FORM

APPLICANT INFORMATION: Assist the applicant in completing the information in this section. It may be necessary to read or explain this section to the applicant.

A prescription that includes the following information must be attached to this form:

- Person's name (printed or typed)
- Person's date of birth
- Practitioner's state license number and DEA number if applicable
- Practitioner's name (printed or typed)
- Practitioner's signature
- Practitioner's phone number
- Date of prescription
- Type of epilesy medication or insulin (must be on the Department formulary) see list on page 5 and 6 to of this form
- Medication dosage
- Whether and how many refills are allowed

ELIGIBILITY CRITERIA: Determine the applicant's eligibility based on the criteria below:

- Is a self-declared resident of Florida.
- Has epilepsy
- Has diabetes
- Is uninsured, lacking insurance that covers epilepsy medication or insulin, or has an insurance deductible or copay that the applicant cannot afford.
- Has a net family income at or below 100% of the poverty guidelines.
- Has no more than $2,500 in private funds, bank accounts, or assets other than a homestead.
- Is not a current Medicaid recipient.

The CHD will determine eligibility in accordance with their written procedures. The CHD may require documentation of income or accept self-declaration as documentation in accordance with local policy. Self-declaration of Florida residency, insurance status, and assets is acceptable.

If the CHD has an on-site pharmacy, the CHD will retain the original application form.

If the CHD does not have an on-site pharmacy, send the original application and prescription to:

Central Pharmacy
104-2 Hamilton Park Drive
Tallahassee, FL 32304
(850) 922-9036 or (800) 554-4584

CLIENT RECORD REVIEW: CHD staff are encouraged to conduct a quarterly review of client records as part of the CHD quality improvement activities. The record review will assist the CHD in assuring that the program requirements are being followed and that eligibility is being determined and documented according to this guideline. For continued quality improvement, please submit these quarterly updates to the State Office on the Chronic Disease SharePoint site under the Client Record Review Forms for the Medication Assistance Program tab. This will greatly aid central office in monitoring the usage of and need for the program. To protect client's information please remove all personal identifiers. The client record review form on page 7 of this application is provided as a tool to complete the record review. For more information and guidance on this section, contact central office at chronic.hsfcd@flhealth.gov.

Quarter	Due Date
January-March (Quarter 1)	**1st week of April**
April-June (Quarter 2)	**1st week of July**
July-September (Quarter 3)	**1st week of October**
October-November (Quarter 4)	**1st week of April**

EPILEPSY SERVICES PROGRAM (ESP) DRUG FORMUALRY

Drug Name	Generic Drug Name	Route	Dose Form	Strength
AcetaZOLAMIDE	AcetaZOLAMIDE	oral	tablet	250 mg
Carbatrol	CarBAMazepine	oral	capsule, extended release	200 mg
Carbatrol	CarBAMazepine	oral	capsule, extended release	300 mg
KlonoPin	ClonazePAM	oral	tablet	0.5 mg
KlonoPin	ClonazePAM	oral	tablet	1 mg
KlonoPin	ClonazePAM	oral	tablet	2 mg
Depakote	Divalproex sodium	oral	delayed release tablet	125 mg
Depakote	Divalproex sodium	oral	delayed release tablet	500 mg
Zarontin	Ethosuximide	oral	capsule	250 mg
Zarontin	Ethosuximide	oral	syrup	250 mg/5 mL
Neurontin	Gabapentin	oral	capsule	400 mg
Neurontin	Gabapentin	oral	tablet	100 mg
Neurontin	Gabapentin	oral	tablet	300 mg
Lamictal	LamoTRIgine	oral	tablet	25 mg
Lamictal	LamoTRIgine	oral	tablet	100 mg
Lamictal	LamoTRIgine	oral	tablet	150 mg
Lamictal	LamoTRIgine	oral	tablet	200 mg
Keppra	LevETIRAcetam	oral	solution	100 mg/mL
Keppra	LevETIRAcetam	oral	tablet	500 mg
Keppra	LevETIRAcetam	oral	tablet	750 mg
Keppra	LevETIRAcetam	oral	tablet	1000 mg
Ativan	LORazepam	oral	tablet	0.5 mg
Ativan	LORazepam	oral	tablet	1 mg
Ativan	LORazepam	oral	tablet	2 mg
Trileptal	OXcarbazepine	oral	tablet	150 mg
Trileptal	OXcarbazepine	oral	tablet	300 mg
Trileptal	OXcarbazepine	oral	tablet	600 mg
PHENobarbital	PHENobarbital	oral	tablet	15 mg
PHENobarbital	PHENobarbital	oral	tablet	30 mg
PHENobarbital	PHENobarbital	oral	tablet	100 mg
Dilantin	Phenytoin	oral	capsule, extended release	30 mg
Dilantin	Phenytoin	oral	capsule, extended release	100 mg
Dilantin	Phenytoin	oral	suspension	25 mg/mL
Dilantin	Phenytoin	oral	tablet, chewable	50 mg
Lyrica	Pregabalin	oral	capsule	25 mg
Lyrica	Pregabalin	oral	capsule	50 mg
Lyrica	Pregabalin	oral	capsule	100 mg
Lyrica	Pregabalin	oral	capsule	200 mg
Mysoline	Primidone	oral	suspension	250 mg/5 mL
Mysoline	Primidone	oral	tablet	50 mg
Mysoline	Primidone	oral	tablet	250 mg
Gabitril	TiaGABine	oral	tablet	4 mg
Gabitril	TiaGABine	oral	tablet	12 mg
Gabitril	TiaGABine	oral	tablet	16 mg

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Topamax	Topiramate	oral	tablet	25 mg
Topamax	Topiramate	oral	tablet	50 mg
Topamax	Topiramate	oral	tablet	200 mg
Zonegran	Zonisamide	oral	capsule	25 mg
Zonegran	Zonisamide	oral	capsule	50 mg
Zonegran	Zonisamide	oral	capsule	100 mg

INSULIN DRUG FORMULARY	
Humulin R	Short-Acting Insulin
Humulin N	Intermediate-Acting Insulin Known as NPH
Humulin 70/30	Combination Insulin

Medication Assistance Program Application
Client Record Review

Completed by: _____ **Date:**_____

The following is included or documents in the client record: Enter HIPAA complaint client identifier _____	**Enter "Y" for yes, "N" for no or "N/A" for not applicable in the box below**
Insulin Distribution Program Application is completed correctly.	
Eligibility is determined within the past 12 months.	
Eligibility is determined and documented according to criteria.	
Sliding fee assessed if income is between 101 and 200 percent of poverty.	
Current prescription is in record.	
Client was referred to a DSMES program.	
Client was referred to the Epilepsy Service Program.	

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Florida's Epilepsy Service Program Providers

1. Epilepsy Agency of the Big Bend
   Counties served: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
   Address: 1302 East Sixth Avenue, Tallahassee, FL 32303
   Phone: 850-222-1777
   Email: info@eabb.org
   Website: https://eabb.org/

2. Epilepsy Services Southwest Florida
   Counties served: Charlotte, Collier, Desoto, Glades, Hendry, Lee, Manatee, and Sarasota
   Address: 1750 17th Street, Building I-2, Sarasota, Florida 34234
   Phone: (941) 953-5988
   Email: admin@esswfl.org
   Website: https://epilepsy-services.org/

3. Epilepsy Alliance Florida
   Counties served: Alachua, Baker, Bradford, Broward, Citrus, Clay, Columbia, Dade, Dixie, Duval, Escambia, Flagler, Gilchrist, Hamilton, Hernando, Indian River, Lafayette, Lake, Levy, Marion, Martin, Monroe, Nassau, Okaloosa, Okeechobee, Palm Beach, Putman, Santa Rosa, St. Lucie, St. Johns, Sumter, Suwannee, Union, Volusia, and Walton
   Address: 7300 N. Kendall Dr. Suite 760, Miami, FL 33156
   Phone: 1-877-553-7453
   Email: info@eafla.org
   Website: http://www.epilepsyalliancefl.org

4. Epilepsy Services of West Central Florida
   Counties served: Hardee, Highlands, Hillsborough and Polk
   Address: 1044 E. Brandon Blvd., Suite 7, Brandon, FL 33511
   Phone: 813-870-3414
   Email: fes@efa.org
   Website: http://epilepsy.com/florida

5. Epilepsy Association of Central Florida
   Counties served: Brevard, Orange, Osceola, and Seminole
   Address: 109 N. Kirkman Road, Orlando, FL 32811
   Phone: 407-422-1416
   Email: contact@epilepsyassociation.com
   Website: https://epilepsyassociation.com/

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