FAX

_____ TOTAL PAGES
(INCLUDING COVER SHEET)

To: Endo Advantage™

Fax #: 1-800-939-3348

From (Practice and Contact Name): ____________________

Phone #: ____________________

Date: ____________________

RE: Request for assistance from Endo Advantage™

Please relay information via:

- ☐ Phone only ____________________
- ☐ Fax only ____________________
- ☐ Phone or fax as needed ____________________

Please provide assistance with the attached materials:

- ☐ Prescription and Benefits Investigation Form
- ☐ Patient Assistance Program Application Form (for patients)
- ☐ Patient Assistance Program Product Request Form (for physicians)
- ☐ Letter of Medical Necessity
- ☐ Appeal Denied Claims Letters
- ☐ Prior Authorization Letters for Drug and Procedures
- ☐ Other ____________________

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