



New Pharmacy Plan

Are You Paying More Than \$100.00 Per Month?

US Pharmaceutical Companies Want To Help!!!

**Thousands of hardworking people like you
Are getting a break on the medicines they need.**

ACTUAL CLIENT EXAMPLE SAVINGS

EZMeds USA provides a simple and affordable prescription plan with name-brand drugs. This unique plan will save you money on virtually every name-brand prescription. Medications are through Patient Assistance Programs sponsored by US pharmaceutical companies.

The Savings are real.

- Members save 50-90% on brand-name prescriptions.
- Over 4,000 brand-name prescriptions.
- Instant savings, financial relief through a Patient Assistance Program to those who can't afford their prescriptions.
- No co-payments or deductibles.
- No maximum usage, hidden fees, or age limits.
- No limit to the number of medications you take.

Apply today in just minutes.

- Over the phone **888-396-3371**
- Or, fill out the attached application and drop in the mail.
- Online: www.ezmedsusa.com

Drug/ Strength	Retail	Discount Price	EZ Meds
Aciphex 20 mg	\$182.00	\$161.00	\$69.95
Topamax 50 mg	\$142.00	\$131.00	\$0.00
Provera 2.5 mg	\$38.00	\$30.00	\$0.00
Estratest HS 0.625/1.25 mg	\$157.00	\$90.00	\$0.00
Total Cost Per Month	\$519.00	\$412.00	\$69.95

Drug/ Strength	Retail	Discount Price	EZ Meds
Advair 250/50Mcg/1disk	\$223.00	\$104.00	\$119.95
Lipitor 10mg	\$95.00	\$88.90	\$0.00
Plavix 75mg	\$158.00	\$141.00	\$0.00
Nexium 40mg	\$182.00	\$163.00	\$0.00
Singulair 10mg	\$122.00	\$111.00	\$0.00
Zolof 25mg	\$118.00	\$103.00	\$0.00
Total Cost Per Month	\$898.00	\$710.90	\$119.95

Drug/ Strength	Retail	Discount Price	EZ Meds
Gleevec 400mg	\$4,250.00	\$3,350.00	\$39.95
Total Cost Per Month	\$4,250.00	\$3,350.00	\$39.95

Drug/ Strength	Retail	Discount Price	EZ Meds
Actos 30mg	\$212.00	\$194.00	\$69.95
Celebrex 200mg	\$134.00	\$115.00	\$0.00
Total Cost Per Month	\$346.00	\$309.00	\$69.95



**You may be eligible.
Here's how to qualify:**

To be eligible for EZ Meds' Patient Assistance Programs, you must meet both requirements listed below...

Step 1:

Household income equal to or less than:

Persons in Family/household	48 Contiguous States and D.C.	Alaska	Hawaii
One person	\$21,660	\$27,060	\$24,920
Two people	\$29,140	\$36,420	\$33,520
Three people	\$36,620	\$45,780	\$42,120
Four people	\$44,100	\$55,140	\$50,720
Five people	\$51,580	\$64,500	\$59,320
Six people	\$59,060	\$73,860	\$67,920
Seven people	\$66,540	\$83,220	\$76,520
Eight people	\$74,020	\$92,580	\$85,120

Step 2:

Rx Coverage 2008 Status:

- No prescription drug coverage (public or private)
- If you have insurance, your prescription drug coverage has run out or your specific medication is not covered

** These are general guidelines and vary from company to company*

Step 3:

Select the plan that is right for you:

# of Prescriptions	Monthly Fee	1x Enrollment Fee	TOTAL
1 **	\$39.95	\$25.00	\$64.95
2—4	\$69.95	\$25.00	\$94.95
5—8	\$119.95	\$25.00	\$144.95
9—12	\$169.95	\$25.00	\$194.95

*** Fees are based upon the prescription we help with.*

PATIENT INFORMATION

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ Home Phone: (_____) _____
 Mobile Phone: (_____) _____ E-Mail Address: _____
 Marital Status: _____ Date of Birth: _____ S.S.# _____
 The best time to contact me: MORNING AFTERNOON
 What is your annual income from all sources? _____

ALTERNATE CONTACT INFORMATION
 (person assisting patient with their medications, if applicable)

Name: _____ Relationship to Patient: _____
 Home Phone: (_____) _____ Work Phone: (_____) _____

PHYSICIAN INFORMATION

(Only list those doctors who prescribe medications listed below)

DOCTOR #1

DOCTOR #2

Name: _____
 Facility Name: _____
 Address: _____
 Suite: _____ City: _____
 State: _____ Zip: _____
 Office Phone: (_____) _____

Name: _____
 Facility Name: _____
 Address: _____
 Suite: _____ City: _____
 State: _____ Zip: _____
 Office Phone: (_____) _____

PRESCRIPTION INFORMATION

(Please put the prescribing doctor # with each medication)

Dr#	Brand/Generic	Strength	Frequency

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

I want to pay my monthly service fee by:

- BANK DRAFT (IMPORTANT: You must attach a copy of your voided check)
 CREDIT CARD _____ Visa _____ MasterCard

Card #: _____
 Exp. Date: _____ 3-Digit Security Code: _____

DEDUCTION AUTHORIZATION: I authorize EZMeds USA, or its designated attorney-in-fact, to electronically draft my account above or charge my credit card for my application fee and monthly membership. This authorization will remain in full force until EZMeds USA receives written notification from me of termination of service. Please allow 30 days to process cancellation.

Authorized Signature: _____ Date: _____

MAKE CHECK PAYABLE TO EZMeds USA

# of Prescriptions	Monthly Fee	1x Enrollment Fee	TOTAL
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2—4	\$69.95	\$25.00	\$94.95
5—8	\$119.95	\$25.00	\$144.95
9—12	\$169.95	\$25.00	\$194.95

Provider: _____

EZ Meds USA (EZ Meds) General Information

You understand: that not all medications you are taking may be available through the pharmaceutical companies free drug programs and each company has income and pharmacy coverage guidelines.

Your gross yearly family income needs to be less than illustrated on the income chart and each pharmaceutical company may have different guidelines. Also, you currently have no coverage (insurance or government program) that reimburses or pays for your prescription medications and you are experiencing a hardship in purchasing them.

You will be required to provide proof of my income before any services will occur on your behalf.

One your applications have been completed by EZ Meds, they will be mailed to your doctor for his/her signature. Your doctor will then mail them back to EZ Meds so they may be forwarded to the appropriate pharmaceutical company(s). EZ Meds cannot be held responsible if applications are not returned by the doctor.

Once the completed applications for the pharmaceutical companies PAPs (free drug programs) are returned to EZ Meds it may take 6-8 weeks before you would receive the first shipment of medications (generally a 90 day supply). The pharmaceutical company determines whether my medication is shipped to the physician, picked up at a local pharmacy, or shipped directly to your home. Clients or EZ Meds cannot decide where medications are to be delivered.

You are authorizing the alternate contact, if filled-in, on the Enrollment Form be approved to act on my behalf with regards to my account/records with EZ Meds. You can cancel your service at any time, but no refund will be issued.

With regard to the pharmaceutical companies PAPs, EZ Meds acts only as a processing assistant to help you apply for and complete applications necessary to receive free drugs offered by pharmaceutical companies we do not manufacture drugs, prescribe drugs, dispense drugs, recommend medication, or evaluate prescriptions.

You attest that the information provided in this application is complete and accurate. By your signature, I authorize EZ Meds USA, LLC. to request and obtain from my healthcare provider, insurance company, or pharmaceutical company/manufacturer or its contractors any of my medical records and information, financial and insurance records and information, and/or any other information necessary for the purpose of verifying the accuracy of the information provided in this application or related to my enrollment or participation in the various pharmaceutical patient assistance programs (PAPs). I understand that any such information obtained, as well as the information provided to me in this application, will be used by EZ Meds USA, LLC. and its authorized agent(s) solely to administer the PAPs and those services provided only by EZ Meds USA, LLC., but will not be used or disclosed for any other purposes, except as may be required by applicable law. I understand that neither EZ Meds USA, LLC. Nor my healthcare provider may be held responsible in the event I provide information deemed to be fraudulent. Please include proof of income, latest tax return (first page only) or Social Security income statement.

Temporary Power of Attorney

1. I _____ give "EZ Meds USA" and is representative(s) permission to apply for medication assistance programs on my behalf. "EZ MedsUSA" will have limited Power of Attorney to sign any necessary paperwork, applications and/or documentations concerning the assistance programs.
2. I understand that I may revoke my authorization at any time by providing a written request of termination of services with "EZ Meds USA", Processing Center, P.O. Box 43064, Las Vegas, Nv 89116.
3. A copy of this authorization may be accepted as an original.

Member's Name (Print) (_____-)(_____-)(_____-)
Member's Social Security Number

Member's Signature Date

Name of Personal Representative (If applicable) Relationship to Member

PLAN ADMINISTRATOR:



P.O. Box 15640 • Scottsdale, Arizona 85267

Local (480) 502-3773 • Fax (480) 502-3993

Toll Free: 888-396-3371