BioForm Medical, Inc.
Patient Access Program
Application Form (Page 2 of 2)

RADIESSE® A NATURAL LOOK THAT LASTS for FACIAL LIPO-ATROPHY HIV

Physician's Name: _____

DEA#: _____

PATIENT INFORMATION (to be filled out by practitioner)

_____

Name of Patient Date of Birth

_____

Address City State Zip

_____

Phone Number SS#

Please complete the following information:

1. Patient's ANNUAL income, including social security and pension benefits: $ _____
2. The product use for this patient is consistent with the following FDA-approved indication for RADIESSE dermal filler: RADIESSE dermal filler is *intended for restoration and/or correction of the signs of facial fat loss (lipoatrophy) in people with human immunodeficiency virus.* Yes No
3. Patient qualifies for insurance coverage for RADIESSE in a private or public program. Yes No

PATIENT STATEMENT AND AUTHORIZATION

By signing this document, I agree to allow specific parties to disclose records of my health insurance coverage to BioForm Medical, Inc. (BioForm Medical) for purposes of evaluating my application to participate in the RADIESSE Patient Access Program (PAP). The parties who are authorized to disclose such records are limited to my insurer, my employer, my hospital and my physician. BioForm Medical may use this information only for purposes of evaluating my eligibility to participate in PAP and only until a decision has been made with respect to my eligibility to participate in PAP, unless I give consent with respect to an additional or extended use. I understand that once my insurance information is released to BioForm Medical, it is no longer protected by federal privacy laws. I also understand that BioForm Medical reserves the right to modify or discontinue PAP and its eligibility criteria at any time without further notice to me. I have read this document and understand it. The information I have provided above, including my income and insurance status, is complete and accurate; and I represent that I am not eligible for and do not have any sort of insurance coverage for RADIESSE dermal filler.

_____

Patient's Signature Date

BIOFORM™ MEDICAL

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