PERNIX THERAPEUTICS

Patient Assistance Program
Enrollment Form

Your consent and release of information

By my signature I authorize Pernix Therapeutics, as well as any other companies Pernix Therapeutics uses to administer the patient assistance program (the "Program"), to do the following:

1. Use information contained on my application for the purpose of helping me receive certain prescription medications pursuant to my participation in the Program;
2. Administer the Program;
3. Receive and keep records for all prescriptions medications I receive under the Program;
4. Contact my healthcare providers about my application for the Program;
5. Disclose information contained in my application to my healthcare providers to provide me with prescription medications;
6. Contact and request information from my insurer, the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations, or my healthcare providers about the prescribed medication I receive or will receive under the Program, about my medical condition or about my eligibility for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my healthcare providers. This information will be used only to determine my eligibility for the Program and to administer the Program; and
7. Disclose any information obtained from my application and the sources listed about to third parties if required by law.

By signing below, I also authorize my healthcare providers to release information about my prescribed medications and medical condition that is requested by Pernix Therapeutics or any company that Pernix Therapeutics uses to administer the Program.

I agree to provide to Pernix Therapeutics with any requested documentation to verify that the information provided is correct, including bank statements, Federal Tax Returns, verification of non-filing for Federal Tax, W-2 forms, denial from insurance companies or state or government programs, etc.

I understand that this authorization will remain in effect for as long as I participate in the Program and for a period of three (3) years after my participation in the Program ends. I understand that if my participation in the Program lapses or if I re-enroll in the Program, I may be asked to sign another authorization.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing a signed written letter to Pernix Therapeutics stating the same. Such revocation will end my eligibility in the Program. Revoking this authorization will prohibit disclosures after the date written revocation is received by Pernix Therapeutics except to the extent that the action has been taken in reliance on my authorization or as required by law. I understand that once information has been disclosed in reliance upon this authorization, the information may no longer be protected by federal privacy laws and may be further disclosed by the recipients of the information.

I understand that Pernix Therapeutics does not charge a fee for participation in the Program and Pernix Therapeutics is not responsible for any copayment or other fee charged by any other party as part of obtaining a prescription or filling a prescription. I understand Pernix Therapeutics reserves the right to cancel or modify the Program, or my participation in the Program at any time. Although medication may be given to me without cost now or at some point in the future, it does not mean that I will be entitled to receive it without cost indefinitely. I understand that the eligibility for enrollment in the Program is subject to Pernix Therapeutics's approval. Pernix Therapeutics reserves the rights to make a separate, independent determination of patient eligibility. I agree to notify Pernix Therapeutics immediately of any changes that might affect my eligibility.

I certify that I am not enrolled in any Medicare plan that includes Part D drug coverage or any other government or private prescription drug plan. I understand that if I enroll in any other prescription drug plan, I may no longer meet the eligibility requirements of this assistance program, even if the benefit program does not cover the full cost of, or places limits on, medications. Furthermore, I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify Pernix Therapeutics of any change in my insurance eligibility, under any other government or private prescription drug plan or change in my financial status. By signing below, I consent to Pernix Therapeutics verifying any information provided on this application and affirm that my answers are accurate to the best of my knowledge.

SIGN

Applicant Signature _____ Date _____ Relationship if other than applicant _____

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