COLORADO
Department of Regulatory Agencies
Division of Insurance

COLORADO
Department of Health Care Policy & Financing

Epinephrine Auto-Injector Affordability Program

The Epinephrine Auto-Injector Affordability Program was created by HB23-1002. Use this application if you need access to a low-cost epinephrine auto-injector.

Who qualifies for the Epinephrine Auto-Injector Affordability Program?

To be eligible for this program you must:

- Be a resident of Colorado
- Have a valid Epinephrine Auto-Injector prescription
- Pay more than $60 for a 2-pack of Epinephrine Auto-Injectors, regardless of the amount or type of Epinephrine Auto-Injector
- Not be eligible for or enrolled in Health First Colorado or Medicare
- Present identification proving Colorado residency including, but not limited to, a valid Colorado identification card or driver's license, a printed bill (utility, telephone, internet, cable, insurance, mortgage, rent, waste disposal, water or sewer, medical or other bill), a credit card or bank statement, a pay stub or earnings statement, a post-marked change of address confirmation, a printed rent receipt or residential lease, a transcript or report card from an accredited school, a vehicle title or registration, an insurance policy, a government issued letter or state or federal government issued check, or a record of medical service. In the case of a minor, the minor's parent or guardian must provide a document with the parent or guardian's printed name and Colorado residential address to demonstrate the minor's proof of residency.

If you qualify for the Epinephrine Auto-Injector affordability program, you may be required to pay a $60 co-pay for each 2-pack of Epinephrine Auto-Injectors. An individual who is eligible to receive Epinephrine Auto-Injectors through the program may receive Epinephrine Auto-Injectors as prescribed for 12 months.

How do I apply?

You must complete page two of this document and give it to your pharmacist.

You must either:

- Fill in the form on page two electronically and then print it. Sign the form by hand.
- Print the document. Fill in the form on page two by hand. Sign the form by hand.

If you are unable to print the document, your pharmacist should be able to provide you a paper copy to complete at the pharmacy.

Questions

If you have questions about the Colorado Epinephrine Auto-Injector Affordability Program, contact your pharmacy, or contact the Colorado Division of Insurance by visiting the Prescription Affordability Programs page.

Privacy Notice

The information requested on this form is needed by your pharmacy to process your request for a low-cost Epinephrine Auto-Injector. The information is collected, maintained and shared as required under § 12-280-142 C.R.S. (Colorado Revised Statutes).

Epinephrine Auto-Injector Affordability Program Application

Your Personal Information

Do you live in Colorado? (If you do not live in Colorado, you are not eligible for this program.)
☐ Yes ☐ No

First Name _____ Last Name _____ Date of Birth _____

Phone Number _____ Email address (optional) _____

Home Street Address _____ City _____ State _____ Zip Code _____

Mailing Address (if same as above, leave blank) _____

City _____ State _____ Zip Code _____

Health Care Coverage / Prescription Information

1. Do you have a current prescription for an Epinephrine Auto-Injector?
   ☐ Yes ☐ No
2. Are you currently enrolled in Medicaid (Health First Colorado) or Medicare?
   ☐ Yes ☐ No
3. Do you have health insurance and pay $60 or less each month to purchase a 2-pack of Epinephrine Auto-Injectors? (Please ensure your insurance card says "CO-DOI," if your card does not say "CO-DOI," meaning your plan is not regulated by the Colorado Division of Insurance, you *are only eligible* if you pay more than $60 for a 2-pack)
   ☐ Yes ☐ No

You may qualify for a manufacturer's patient assistance program. For more information on manufacturer's patient assistance programs, visit foodallergy.org.

Signature and Date

By signing and dating below, you agree that all information is truthful. If you are a minor under the age of 18, your parent/guardian must sign and date the application on your behalf and provide proof of residency.

Print Name (of guardian if applicant is a minor) _____

Signature _____ **Date** _____

Official Pharmacy Use (please keep in your records for two years following the date the Epinephrine Auto-Injector was dispensed)
I confirm that this individual had a valid prescription and presented the following valid form of identification:

☐ **Proof of residency in Colorado.**
Enter document number _____
☐ **Other identification. Please specify** _____
Signature of Pharmacist _____ **Date** _____