

Welvista
121 Greystone Blvd.
Columbia, SC 29210-8002
803-933-9183 x 400
800-763-0059
www.welvista.org



Dear Applicant,

Welvista's Medication Assistance Program is a non-profit mail order pharmacy and is completely free to low income, **uninsured** South Carolina residents who qualify. There is no fee to apply and no charge for any medications you receive from Welvista.

To participate in our program, complete the enclosed application and submit the required documents (highlighted below) to Welvista. Eligibility requirements, detailed instructions, and acceptable proof of income are on the back of the application. **Your application will be returned to you if any of the highlighted items below are not included,**

1. **APPLICATION** – Complete ALL sections. Make sure you complete the INSURANCE and MEDICATION ALLERGIES sections on the application.
2. **PROOF OF WHERE YOU LIVE** - A copy of your Driver's License, State ID Card, utility bill, or any bill with **your** name and current street address printed on it - the street address listed on the application (not your PO Box).
3. **PHOTO ID** – This can be a copy of your Driver's License, State ID Card, or passport. Please contact us if you do not have a photo ID.
4. **PROOF OF INCOME FOR EVERYONE IN YOUR HOUSEHOLD** - Welvista considers your household to be everyone who lives together under the same roof. If no one in your home has any income, call us for a **No Income form** or you may print one from our website. The completed No Income form must indicate how you pay for housing, food and utilities.
5. **PRESCRIPTIONS** – Include new prescriptions you need filled. Make sure the medications your need are on the enclosed drug list or on the detailed medication list on our website. **If your doctor gave you paper prescriptions, the originals must be mailed (not faxed) to Welvista.** See enclosed Pharmacy Quick Facts.

You have three ways to submit your application and supporting documents:

- 1) MAIL to Welvista 121 Greystone Blvd, Columbia, SC 29210
- 2) SCAN and EMAIL to applications@welvista.org
- 3) FAX to 803-254-0892

If you have questions, call the phone number above. Allow 10-14 days for your application to be processed. You will receive a letter notifying you about your enrollment. We look forward to serving you.

Sincerely,

Welvista Patient Services

Enclosures

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

YOU SHOULD ALSO SHARE A COPY OF THIS NOTICE WITH YOUR FAMILY MEMBERS, FRIENDS, ETC. WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE.

This notice affirms that Welvista is dedicated to maintaining the privacy of your health information. In our operations, we create records regarding you and the benefits/services we provide you. This Notice will tell you about the ways in which we may use and disclose medical information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Maintain the privacy of your health information, also known as PHI
- Provide you with this Notice, and
- Comply with this Notice

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this Notice, we will distribute the new Notice to you within 60 days of the revision. You may obtain a paper copy of the current Notice by contacting Welvista using the contact information we provide at the end of this Notice.

HOW WELVISTA MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your PHI for certain purposes without your permission or authorization. The following gives examples of each of these circumstances.

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses, and other professionals who are involved in your care.
2. **For Payment.** We may use or disclose your PHI to provide payment for, or stock replenishment of the treatment you receive under the Welvista benefit.
3. **For Health Care Operations** We may use or disclose your PHI for our health care operations. For example, we may verify periodically your eligibility status with the state Medicaid system or other insurance benefits, which may be responsible for the cost-management and planning of your medications.
4. **To the Plan Sponsor** We may disclose your PHI to Welvista executive and planning personnel only for purposes of maintaining your eligibility for enrollment in the plan.
5. **For Health Related Plans and Services** Welvista may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
6. **To Individuals Responsible for Your Care** We may disclose your PHI to a family member or friend who is involved in your medical care provided that you agree to this disclosure, or we give you the opportunity to object to this disclosure. However, if you are unavailable or are unable to agree or object, we will use our best judgment to decide whether this disclosure is in your best interest.
7. **For Audits.** We may disclose your PHI to third parties for audit purposes in connection with grant or public funding assistance for pharmaceutical and medical treatment needs of the patient.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATION

The law allows us to disclose your PHI in the following circumstances without your permission or authorization.

1. **When Required by Law.** We will use and disclose your PHI when we are required to do so by federal, state, or local law.
2. **For Public Health Risks** We will use and disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders, and dependent adults.

3. **For Health Oversight Activities** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits, and licensure.
4. **For Lawsuits and Disputes** We may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request of obtain an order protecting the information the party has requested.
5. **To Law Enforcement** We may release PHI if asked to do so by a law enforcement official in the following circumstances.
 - Concerning a death we believe might have resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena, or similar legal process;
 - To identify/locate a suspect, material witness, fugitive, or missing person
 - In an emergency, to report a crime(including the location or victim(s) of the crime or the description, identity or location of the person who committed the crime)
6. **To Avert a Serious Threat to Health or Safety** We may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.
7. **For Military Functions/ National Security** Your PHI may be disclosed if you are a member of the US or foreign military forces, and if required to by the appropriate military command authorities. We may also disclose PHI about you to federal officials for intelligence and national security activities authorized by law. We may also disclose PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates** We may disclose PHI to a correctional facility if you are an inmate or under the custody of a law enforcement official

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain.

1. **Right to Request Confidential Communication**
2. **Right to Request Restrictions in use of your PHI**
3. **Right to Inspect and Copy your PHI**
4. **Right to Request Amendment to your PHI**
5. **Right to an Accounting of Disclosures**

We are not required to agree to your requests, but will do everything within our means to accommodate any legitimate request.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH WELVISTA'S PRIVACY OFFICER, OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

To file a complaint with us, you must submit in writing to the address listed at the end of this Section. **We will not retaliate against you for filing a complaint.**

If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

Welvista
ATTN: HIPAA Compliance Officer
121 Greystone Blvd.
Columbia, SC 29210-8002
Tel (803)-933-9183

or

The Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201



121 Greystone Blvd.
Columbia, SC 29210
803-933-9183
Fax 803-254-0892
www.welvista.org

Before you mail your application, please check each of the following.

- Is this a renewal application? Yes No
- Is each section completed? Yes No
- Did you sign and date the application? Yes No
- Did you attach proof of income? Yes No
- Did you attach a copy of your photo ID? Yes No
- Did you attach proof of your street address? Yes No

PATIENT INFORMATION

Last Name:	First:	MI:	Social Security Number	Birth Date
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Patient Address (where you receive your mail)	City	State	Zip
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Patient Address (where you live) (attach proof of street address to application)	City	State	Zip
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County in South Carolina	Home#/Cell#	Work or alternate#
Ethnic Origin: Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Are you a legal resident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Doctor/Clinic/Healthcare Provider		List all medications you are allergic to. If no allergies, write "NO."
Doctor/Clinic/Healthcare Provider's phone#		
Check number of people who live in your household including self:		
1 2 3 4 5 6 7 8 9		

Do you have (please check) Health Insurance/Affordable Care Act Medicare Medicaid Family Planning /Healthy Check Up VA Health
I do not have any medical health insurance

PATIENT ELIGIBILITY INFORMATION

List all household income, gross monthly amounts

Salary/Wages	\$ _____
Disability	\$ _____
Alimony/Child Support	\$ _____
Social Security	\$ _____
Pension/Retirement	\$ _____
Unemployment/Work Comp	\$ _____
Total Gross Household Monthly Income:	\$ _____

ATTACH PROOF OF HOUSEHOLD INCOME

Include proof of ALL household income - wages (2 current consecutive paystubs), pension/retirement, social security, SS disability with Notice of Award, child support, alimony, unemployment, worker's compensation, rental income, etc. SEE BACK FOR ADDITIONAL INCOME INFORMATION

AGREEMENT/ DISCLOSURE / RELEASE

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to Welvista and/or their agents. I authorize Welvista and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Welvista program, which may include contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities Welvista may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista may request additional documentation to authenticate the statements made on my application. **I will notify Welvista if I become eligible for Medicare, Medicaid, Health Insurance, VA Health Benefits, or if there is a change in my financial status or my mailing address changes.** I have received Welvista's Notice of Privacy Practices Statement.

Patient/Guardian signature _____ Date _____

WELVISTA USE ONLY

Approved/Denied _____ MR # _____ Keyed _____

Plan ID _____ AC Health _____

Pt Adv _____ SCT **DOC**

Approval Date _____ Exp Date _____

Facility _____ FP # _____

DOCTOR/CLINIC USE ONLY

Doctor/Clinic _____

Hospital _____

HOP# _____ HOP ID# _____

Access Health Group _____

Welvista Application Instructions

To Qualify, you:

- ✓ Must be a legal resident of South Carolina
- ✓ Cannot have Medicare, Medicaid (except Family Planning/Healthy Connections Checkup), VA Health Benefits, Private Health Insurance or Affordable Care Act
- ✓ Household income must be at or below 250% of the Federal Poverty level. Refer to this chart. →

Return completed application, photo ID, proof of street address, and proof of income for everyone in your home to:

Welvista, 121 Greystone Blvd. Columbia, SC 29210

2024 HHS Federal Poverty Guidelines**

**Gross income before taxes and/or any deductions

# in Household	Monthly Gross Income	Yearly Gross Income
1	\$3,138	\$37,650
2	\$4,258	\$51,100
3	\$5,379	\$64,550
4	\$6,500	\$78,000
5	\$7,621	\$91,450
6	\$8,742	\$104,900
7	\$9,863	\$118,350
8	\$10,983	\$131,800
For each additional person add	\$1,121	\$13,450

- 1. PROOF OF PHYSICAL ADDRESS**- Provide proof of where you live (street address you listed on the application)
- 2. PHOTO ID** – A copy of your driver's license, state ID card, or passport. **Call us if you do not have a photo ID.**
- 3. PROOF OF INCOME: For each person in your home who has income**, attach all of the following items listed below that apply. If you are not sure what to send, call and we will help you.

Job

- Send 2 current consecutive pay stubs no older than 45 days, with no weeks missing in between, showing your/your household's GROSS income (with any deductions listed), not NET. We cannot accept copies of checks or bank statements.
- You may instead send a signed and dated letter from your/your household's employer stating what work is done, if there are any deductions from pay, the GROSS rate of pay, and the number of hours worked for the last 2 weeks. You may send a completed copy of Welvista's Employer Statement of Income.

Commission –Please send 1 month of documentation stating commission earnings.

Odd jobs/work for family, friends or neighbors – Send a signed and dated letter from those you/your household do work for stating what work is done, the GROSS rate of pay (with any deductions listed), and the number of hours worked for the last 2 weeks.

Self-employed – Send your/your household's most recent Federal 1040 tax return and the Schedule C – Business Profit or Loss worksheet or you may send a completed copy of Welvista's Self Declaration of Income Form. Call Welvista if you need this form.

Unemployment – Send Unemployment Benefit Statement showing the weekly amount received as well as the benefit-year-end date (BYE). It must be clear you are currently receiving benefits. We cannot accept copies of checks.

Social Security Retirement/Social Security Disability – Send the Social Security New Benefit Amount letter showing MONTHLY amount received for the CURRENT year. **If you are the person applying and you receive social security disability you must also send your Notice of Award or entitlement letter from Social Security that shows the month and year you became entitled to disability.** You must be within the first two years of disability when you do not qualify for Medicare. We cannot accept copies of checks or bank statements.

Other Retirement/Pension/Annuity – Send the current benefit statement showing the monthly amount received with any deductions OR a copy of Form 1099. We cannot accept copies of checks or bank statements.

Child Support/Alimony – Send a copy of a current statement from the clerk of court or a copy of the entire divorce decree stating amount received and how often.

No Income – If no one in your home has any income, submit a fully completed No Income form. We need to know how you are paying for your housing, food, and utilities. The person providing support cannot live in same household as the patient. Call Welvista if you need this form.

NOTE: Welvista enrollment is for up to one (1) year. Once approved, you will be eligible for any medications on our current drug list. Medications are shipped from our pharmacy in Columbia to the mailing address listed on your application. Prescriptions are filled for a 90 day supply whenever possible.

Please call us at 803-933-9183 x 400, if you have questions or need assistance, between 8:30am and 5:00pm EST, Monday through Friday, or visit our website at www.welvista.org.



December 2023 The following medications are available through the **Welvista Medication Assistance Program**. Please check our website at www.Welvista.org for the current dosages and recent updates. The medication and dosage must be listed on the Welvista Formulary in order to be filled from our pharmacy.

Pharmacy **telephone** number – **(803) 933-9184** Pharmacy **fax** number – **(803) 933-0489**

****IMPORTANT—Prescriptions should be written for a 90 day supply****

(ONLY DOCTORS OFFICES MAY FAX PRESCRIPTIONS)

Acetaminophen (325mg, 500mg, 650mg)
Acyclovir (200mg, 400 mg, 800 mg)
Acyclovir (5%)
ADMELOG (vials/Solostar)® (100 units/ml)
ADVAIR HFA INHALER® (230-21mcg)
Albuterol Sulfate HFA (90mcg)
Albuterol Sulfate Nebulizer Solution (0.083%)
Alendronate (35mg, 70mg)
Allopurinol (100mg, 300mg)
Amiodarone (100mg, 200mg, 400mg)
Amitriptyline HCL (10mg, 25mg, 50mg, 75mg, 100mg, 150mg)
Amlodipine Besylate (2.5mg, 5mg, 10mg)
Amoxicillin (250mg, 500mg, 875mg)
Amoxicillin/ Clavulanic Acid (500mg, 875mg)
Anastrozole (1mg)
ANORO ELLIPTA® (62.5/25mcg)
APIDRA (vials, Solostar)® (100 units/ml)
Aripiprazole (2mg, 5mg, 10mg, 15mg, 20mg, 30mg)
ARNUITY ELLIPTA® (50mcg, 100mcg, 200mcg)
Aspirin (81mg, 325mg)
Atenolol (25mg, 50mg, 100mg)
Atorvastatin Calcium (10mg, 20mg, 40mg, 80mg)
Azathioprine (50mg)
Azelastine Nasal (0.1%)

Azithromycin (250mg, 500mg)
Baclofen (5mg, 10mg, 20 mg)
BASAGLAR KWIKPEN® (100 Units/ml)
Benazepril (5mg, 10mg, 20mg, 40 mg)
Benazepril/HCTZ (10/12.5mg, 20/12.5mg, 20/25mg)
Benzotropine (0.5mg, 1 mg, 2 mg)
BREO ELLIPTA® (100/25mcg, 200/25mcg)
Brimonidine Ophthalmic (0.2%)
Bumetanide (0.5mg, 1mg, 2mg)
Bupropion HCL (75mg, 100mg)
Bupropion HCL SR (100mg, 150mg, 200mg)
Bupropion XL (150mg, 300 mg)
Buspiron (5mg, 7.5mg, 10mg, 15mg, 30mg)
Calcitriol (0.25mcg, 0.5mcg)
Calcium Acetate (667mg)
Carvedilol (3.125mg, 6.25mg, 12.5mg, 25mg)
Cefdinir (300mg)
Celecoxib (50 mg, 100mg, 200mg, 400mg)
Cephalexin (250mg, 500mg)
Cetirizine (5mg, 10mg)
Chlorthalidone (25 mg, 50 mg)
Cilostazol (50mg, 100mg)
Ciprofloxacin (250mg, 500mg, 750mg)
Ciprofloxacin Ophthalmic (0.3%)
Citalopram (10mg, 20mg, 40mg)
Clarithromycin (250mg, 500mg)

Clindamycin (150mg, 300mg)
Clonidine (0.1mg, 0.2mg, 0.3mg)
Clopidogrel bisulfate (75mg)
Colchicine (0.6 mg)
Colestipol (1gm)
CYMBALTA® (20mg, 30mg, 60mg)
DEPAKOTE DR® (125mg, 250mg, 500mg)
DEPAKOTE ER® (250 mg, 500mg)
DEPAKOTE SPRINKLE® (125mg)
Desipramine (10mg, 25mg, 50mg, 75mg, 100mg, 150 mg)
Desvenlafaxine Succinate Monohydrate (25mg, 50mg, 100mg)
Diclofenac Sodium DR (25mg, 50mg, 75mg, 100mg)
Diclofenac Sodium Gel (1%)
Dicyclomine (10mg, 20mg)
Digoxin (0.125mg, 0.25mg)
Diltiazem ER/XL (120 mg, 180 mg, 240 mg)
Diltiazem HCL (30mg, 60mg, 90mg)
Diphenhydramine (25mg, 50mg)
Docusate (100mg)
Donepezil (5mg, 10 mg)
Dorzolamide Hydrochloride ophthalmic Solution (2%)
Doxepin (3mg, 6mg, 10mg, 25mg, 50mg, 75mg)
Doxycycline Hyclate (100 mg)
ELIQUIS® (2.5mg, 5mg)
ELMIRON® (100mg)
Enalapril (2.5mg, 5mg, 10mg, 20mg)



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Pharmacy **telephone** number – **(803) 933-9184** Pharmacy **fax** number – **(803) 933-0489**

****IMPORTANT—Prescriptions should be written for a 90 day supply****

(ONLY DOCTORS OFFICES MAY FAX PRESCRIPTIONS)

Enalapril/HCTZ (5/12.5mg, 10/25mg)
Epinephrine Auto-Injector (0.15mg, 0.3mg)
Escitalopram (5mg, 10mg, 20mg)
Esomeprazole DR (20mg, 40mg)
Estradiol (0.5mg, 1mg, 2mg)
Estradiol Patches (0.025mg, 0.0375mg, 0.05mg, 0.075mg, 0.1mg)
Estradiol Vaginal Cream (0.1%)
Estradiol Vaginal Tablet Insert (10mcg)
EVISTA® (60mg)
Ezetimibe - Simvastatin (10mg-10mg, 10mg-20mg, 10mg-40mg, 10-80mg)
Ezetimibe (10 mg)
Famotidine (10mg, 20mg, 40mg)
Febuxostat (40mg, 80mg)
Fenofibrate (48mg, 54mg, 67 mg, 134 mg, 145mg, 160mg)
Ferrous Sulfate (325mg)
Fesoterodine fumarate (4mg, 8mg)
Finasteride (1mg, 5mg)
FLOVENT DISKUS® (50mcg, 100mcg, 250mcg)
FLOVENT HFA INHALER® (44mcg, 110mcg, 220mcg)
Fluconazole (100mg, 150mg, 200mg)
Fluticasone Propionate (50mcg/spray)
Folic Acid (1mg)
Furosemide (20mg, 40mg, 80mg)
Gabapentin (100mg, 300mg, 400mg, 600mg, 800mg)

Gemfibrozil (600mg)
Glimepiride (1mg, 2mg, 4mg)
Glipizide (5mg, 10mg)
Glipizide ER (2.5mg, 5mg, 10mg)
GLUCAGEN HYPOKIT® (1mg)
Haloperidol (1 mg, 2 mg, 5 mg, 10 mg)
HUMALOG 100U/ML INJECTION (vial, kwikpen)® (100 Units/ml)
HUMALOG MIX 50/50 INJECTION (kwikpen)® (50/50 Units/ml)
HUMALOG MIX 75/25 INJECTION (vial, kwikpen)® (75/25 Units/ml)
HUMULIN 70/30 (vial)® (70-30 Units/ml)
HUMULIN N 100U/ML (vial)® (100 Units/ml)
HUMULIN R 100U/ML (vial)® (100 Units/ml)
Hydralazine HCl (10 mg, 25mg, 50mg, 100mg)
Hydrochlorothiazide (12.5mg, 25mg, 50mg)
Hydrocortisone Topical Cream (2.5%)
Hydroxychloroquine (200mg)
Hydroxyzine HCl (10mg, 25mg, 50mg)
Hydroxyzine Pamoate (25mg, 50mg, 100 mg)
Ibuprofen (400mg, 600mg, 800mg)
Imiquimod (5%)
IMITREX NASAL SPRAY® (5mg, 20mg)
INCRUSE ELLIPTA® (62.5mcg)
INVOKAMET XR® (150/1000mg, 150/500mg, 50/1000mg)

INVOKAMET® (50/500mg, 50/1000mg, 150/500mg, 150/1000mg, 50/500mg)
INVOKANA® (100mg,300mg)
Ipratropium/Albuterol Nebulizer Solution (0.5mg/3mg)
Isosorbide Dinitrate (5mg, 10mg, 20mg, 30mg)
Isosorbide Mononitrate ER (30mg, 60mg, 120mg)
JANUMET XR® (50/500mg, 50/1000mg, 100/1000mg)
JANUMET® (50/500mg, 50/1000mg)
JANUVIA® (25mg, 50mg, 100mg)
Ketoconazole Cream (2%)
Ketoconazole Shampoo (2%)
Ketorolac (0.5%)
Ketotifen (0.025%)
Labetalol HCL (100mg, 200mg, 300mg)
LAMICTAL XR (25mg, 50mg, 100mg, 200mg, 250mg, 300mg)
LAMICTAL® (25mg, 100mg, 150mg, 200mg)
Lancets, Insulin Disposable (30G)
LANTUS (vials, Solostar)® (100 units/ml)
Latanoprost Ophthalmic (0.005%)
LEVEMIR 100 UNITS/ML (vial, flexpen)® (100 Units/ml)
Levetiracetam (250mg, 500mg, 750mg, 1000mg)
Levofloxacin (250mg, 500mg, 750mg)
Lisinopril (2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg)



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Pharmacy **telephone** number – (803) 933-9184 Pharmacy **fax** number – (803) 933-0489

****IMPORTANT—Prescriptions should be written for a 90 day supply****

(ONLY DOCTORS OFFICES MAY FAX PRESCRIPTIONS)

Lisinopril/HCTZ (10/12.5mg, 20/12.5mg, 20/25mg)
Lithium (150 mg, 300 mg, 600 mg)
Lithium ER (300 mg, 450 mg)
Loperamide (2mg)
Loratadine (10mg)
Losartan (25mg, 50mg, 100mg)
Losartan/ HCTZ (50/12.5mg, 100/12.5mg, 100/25mg)
Lubiprostone (8mcg, 24mcg)
Magnesium Oxide (400mg)
Meclizine (12.5mg, 25mg)
Medroxyprogesterone (2.5mg, 5mg, 10mg)
Melatonin (1mg,5mg)
Meloxicam (7.5mg, 15mg)
Memantine (5mg, 10mg)
Metformin HCL (500mg, 850mg, 1000mg)
Metformin HCL ER (500mg, 750 mg)
Methimazole (5mg, 10mg)
Methotrexate (2.5mg)
Methylprednisolone (4mg)
Methylprednisolone dose pack (4mg)
Metoclopramide (5mg, 10mg)
Metoprolol Succinate ER (25mg, 50mg, 100mg, 200mg)
Metoprolol Tartrate (25mg, 50mg, 100mg)
Metronidazole (250 mg, 500 mg)
Metronidazole Topical Gel (0.75%, 1%)
Metronidazole Vaginal Gel (0.75%)
Miconazole Vaginal Cream (2%)

Mirtazapine (7.5 mg, 15mg, 30mg, 45mg)
Montelukast (10mg)
Mupirocin Topical Ointment (2%)
Naproxen (250mg, 375mg, 500mg, 550mg)
Naproxen DR (500mg)
Nefazodone HCL (50mg, 100mg, 150mg, 200mg, 250mg)
Nicotine Patches (7mg, 14mg, 21mg)
Nifedipine ER (30mg, 60mg, 90mg)
Nitrofurantoin Mono-MCR (100mg)
Nitroglycerin SL (0.4mg)
Nortriptyline HCL (10mg, 25mg, 50mg, 75mg)
NOVOFINE NEEDLES® (32G)
NOVOLIN 70/30 (vial)® (70-30 Units/ml)
NOVOLIN N 100 UNITS/ML (vial)® (100 Units/ml)
NOVOLIN R 100 UNITS/ML (vial)® (100 Units/ml)
NOVOLOG 100 UNITS/ML (vial, flexpen)® (100 Units/ml)
NOVOLOG MIX 70/30 (vial, flexpen)® (70-30Units/ml)
Nystatin Topical Cream (100,000u/gm)
Olmesartan (5mg, 20mg, 40 mg)
Olmesartan/HCTZ (20/12.5mg, 40/12.5mg, 40/25mg)
Omega-3 Acid Ethyl Esters (1 gram)
Omeprazole DR (10 mg, 20mg, 40mg)
Ondansetron (4mg, 8mg)
Ondansetron ODT (4mg, 8mg)

Oxcarbazepine (150mg, 300mg, 600mg)
Oxybutynin ER (5mg, 10mg, 15mg)
Pantoprazole Sodium (20mg, 40mg)
Paroxetine (10 mg, 20mg, 30mg, 40mg)
Pen Needles, Insulin Disposable (32G)
Phenytoin Chewable tabs (50mg)
Phenytoin Sodium Extended Release (100mg)
Pioglitazone (15mg, 30mg, 45mg)
Polymyxin B-TMP (10,000U/1mg)
Potassium Chloride ER (10meq, 20meq)
Prasugrel (5mg, 10mg)
Pravastatin (10mg, 20mg, 40mg, 80mg)
Prazosin (1mg, 2mg, 5mg)
Prednisolone (1%)
Prednisone (1mg, 5mg, 10 mg, 20 mg, 50mg)
PREMARIN VAGINAL CREAM® (30 gm tube)
PREMARIN® (0.3mg, 0.45mg, 0.625mg, 0.9mg, 1.25mg)
PREMPHASE® (0.625mg and 0.625/5mg)
PREMPRO® (0.3/1.5mg, 0.45/1.5mg, 0.625/2.5mg, 0.625/5mg)
Prenatal (27mg/0.8mg)
Prochlorperazine (5mg, 10mg)
Progesterone (100mg, 200mg)
Promethazine HCl (12.5mg, 25mg)
Propranolol (10mg, 20mg, 40mg, 60mg, 80mg)



December 2023 The following medications are available through the **Welvista Medication Assistance Program**. Please check our website at www.Welvista.org for the current dosages and recent updates. The medication and dosage must be listed on the Welvista Formulary in order to be filled from our pharmacy.

Pharmacy **telephone** number – **(803) 933-9184** Pharmacy **fax** number – **(803) 933-0489**

****IMPORTANT—Prescriptions should be written for a 90 day supply****

(ONLY DOCTORS OFFICES MAY FAX PRESCRIPTIONS)

PROZAC® (10mg, 20mg, 40mg)
Quetiapine (25mg, 50mg, 100mg, 200mg, 300mg, 400mg)
Quetiapine ER (50mg, 150mg, 200 mg, 300 mg, 400 mg)
Ramelteon (8mg)
Risperidone (0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg)
Rizatriptan (5mg, 10mg)
Ropinirole HCL (0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg, 5mg)
Ropinirole HCL ER (2mg, 4mg, 6mg, 8mg)
Rosuvastatin (5mg, 10mg, 20mg, 40mg)
Senna Plus (8.6/50mg)
SEREVENT DISKUS INHALER® (50mcg)
Sertraline (25mg, 50mg, 100mg)
Simvastatin (5mg, 10mg, 20mg, 40mg, 80mg)
Sodium Bicarbonate (650mg)
SOLIQUA™ (Solostar) (100 units and 33 mcg/ml)
Spirolactone (25mg, 50mg, 100mg)
Spirolactone/HCTZ (25/25mg)
STRATTERA® (10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg)
Sucalfate (1gm)
Sulfamethoxazole/Trimethoprim (400/80mg, 800/160mg)
Sulfasalazine (500mg)
Sulfasalazine DR (500mg)
Sumatriptan (25mg, 50mg, 100mg)
SYMBYAX® (3/25mg, 6/25mg)

SYNTHROID® (25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg)
Tamoxifen (10mg, 20mg)
Tamsulosin (0.4mg)
TEGRETOL XR® (100mg, 200mg, 400mg)
Terbinafine (250mg)
Thiamine (100mg)
Timolol Ophthalmic Solution (0.25%, 0.5%)
Tizanidine (2mg, 4mg)
Topiramate (25mg, 50mg, 100mg, 200mg)
Torsemide (5mg, 10mg, 20mg, 100mg)
TOUJEO (Solostar 3/pack)® (300 units/ml)
TOUJEO MAX (Solostar 2/pack)® (300 units/ml)
Trazodone (50mg, 100mg, 150mg)
TRELEGY ELLIPTA® (100mcg/62.5mcg/25mcg, 200mcg/62.5mcg/25mcg)
TRESIBA FLEXTOUCH® (100 units/ml, 200 units/ml)
Triamcinolone Topical Cream (0.1%)
Triamterene/Hydrochlorothiazide (37.5-25mg)
TRUE METRIX GLUCOMETER® (1 System)
TRUE METRIX TEST STRIPS® (50 ct)
TRULICITY® (0.75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml)
Valacyclovir HCL (500mg, 1000mg)

Valsartan (40mg, 80mg, 160mg, 320mg)
Valsartan/HCTZ (80/12.5mg, 160/12.5mg, 160/25mg, 320/12.5mg, 320/25mg)
Venlafaxine ER (37.5mg, 75mg, 150mg)
Venlafaxine HCL (25mg, 37.5mg, 50mg, 75mg)
Verapamil (40mg, 80mg, 120mg)
VICTOZA® (18mg / 3ml)
Vitamin D2 (1.25mg)
Vitamin D3 (50mcg, 1250mcg)
Warfarin Sodium (1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg)
XARELTO® (2.5mg, 10mg, 15mg, 20mg)
Ziprasidone (20mg, 40mg, 60mg, 80mg)
ZYPREXA® (2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg)
ZEGALOGUE (Autoinjector)® (0.6mg/0.6ml)



WELVISTA PHARMACY QUICK FACTS

- Prescriptions are filled for a 90 day supply whenever possible. Request your doctor write your prescription for a 90 day supply.
- Allow 7 business days delivery time. This time is from the day we receive your prescription request to the day we mail your prescription to the mailing address you listed on your application.
- **If you change your address, you must notify Welvista immediately.** We cannot reship medications sent to wrong addresses.
- You **must** contact the pharmacy each time you need a refill. No prescriptions are refilled automatically.
- You may contact the pharmacy by calling 803-933-9184. This connects you with the automated response system and allows you to enter refill requests using the prescription RX number on your bottle. **This is the fastest way to get your prescription refilled.**
- You may contact the pharmacy to speak with pharmacy staff during business hours.
- You may leave messages for the pharmacy. **Always** leave your name, date of birth and phone number. **Your call will be returned in 24-48 hours.** **Please do not leave more than one message.**
- You may call to refill your prescription **10 days** before you need a refill. Look at your prescription bottle. The label says: **Please call for refill on xx/xx/xxxx.** This is the first day you may call for a refill. **On this day,** you should have 10 days of medicine left. This gives Welvista 10 days to send your medicine so you should not run out.
- **If you have prescription refills at another pharmacy,** we can transfer them to Welvista Pharmacy. You will need to tell our pharmacy the name and phone number of your current pharmacy, and the medications you want to transfer.
- Your doctor may send your prescription by computer, fax, or phone call. **It is illegal for anyone other than your doctor's office to call or fax prescriptions!** **If your physician gives you written prescriptions to have filled, you must mail them to:**
Welvista Pharmacy
121 Greystone Blvd.
Columbia, SC 29210-8002
- Please take the Welvista Drug List with you to your doctor visits or the Emergency Room.
- All medications are supplied to our pharmacy by companies that partner with us. Our drug list may change from time to time as medications are removed or added by our partners. To view our current drug list, please go to our website at <https://www.welvista.org/prescription-assistance/medications-list/>
- Welvista does **not** stock any controlled substance medications.
- You will receive a renewal notice the month before your current application expires.

Welvista, 121 Greystone Blvd, Columbia, SC 29210-8002

Phone 803-933-9184

Fax 803-933-0489

www.welvista.org



No Income Form

NOTE: USE THIS FORM ONLY IF NO ONE IN THE HOUSEHOLD HAS INCOME
Patient must complete SECTION 1 - Person helping the patient must complete SECTION 2
Completed form must be submitted with Welvista application package

SECTION 1 - Patient Information (All information required)

By signing, I verify that **I, OR NO ONE LIVING IN MY HOUSE** have no income. If I, or anyone in my house receives Food Stamps and/or help from the Housing Authority (HUD), **I HAVE ATTACHED A CURRENT STATEMENT FROM EACH ORGANIZATION.**

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

SECTION 2 - Person helping patient (All sections must be completed, including dollar amounts.) We need to know how patient is living day to day (housing, food, and utilities).

By my signature, I verify the above patient's current housing situation, that all information is true, and that no work or services are given in exchange for support. **THE PERSON HELPING THE PATIENT CANNOT LIVE IN THE SAME HOUSE AS THE PATIENT.**

Name of person helping or verifying patient living situation: _____
(Printed name)

Please list the dollar amount you have paid/given in the last 30 days for each item below that applies:

\$ _____ House/Rent (If answer is \$0 state why): _____

\$ _____ Food (If answer is \$0 state why): _____

\$ _____ Utilities (If answer is \$0 state why): _____

\$ _____ Total amount given to patient per month

Date: _____

(Signature of person helping or verifying patient living situation)

OR – Patient has no one over age 18 to vouch for their current living situation:

Date: _____

(Patient Advocate/Case Manager)