pharma& Patient Assistance Program Enrollment Form

PO Box 14852 ◆ Lenexa, KS 66285
Phone: 855-443-7028 ◆ Fax: 833-313-8348
Monday – Friday, 9:00am – 6:00pm ET

Thank you for your interest in the pharma& Patient Assistance Program.
Please complete this form and fax to 833-313-8348

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Gender ❑ M ❑ F

Address _____ E-mail _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Text OK? ❑ Yes ❑ No

Alternate Contact _____ Relationship to Patient _____ Phone _____

❑ US Citizen ❑ Legal Alien ❑ US Resident Only SSN _____

FINANCIAL INFORMATION

YEARLY GROSS FAMILY INCOME: *Please include salary, wages, pension, social security, disability, earnings from dividends or rental property*

NUMBER OF PEOPLE LIVING IN HOUSEHOLD: *Include yourself, spouse, children or other dependents*

INSURANCE INFORMATION *(attach copies of insurance cards, front/back, enlarged)*

PLEASE CHECK ALL THAT APPLY: ❑ No Insurance ❑ Commercial ❑ VA/Military ❑ State Assistance ❑ Medicaid
Medicare: ❑ Part B ❑ Part D ❑ Medicare Advantage ❑ Other:_____

REQUIRED: Medicaid: ❑ Denied/Not Eligible *(Please provide copy of denial letter)* ❑ Not applied ❑ Pending coverage

Insurance Name	ID/Policy #	Group #	Phone #	Policy Holder
Primary Medical Insurance: Please list below				
Secondary Insurance: Please list below				
Prescription Coverage: Please list below				
Prescription PCN #:		**Prescription BIN #:**		

By signing below, I verify that the patient information contained in this enrollment form is complete and accurate to the best of my knowledge. I hereby authorize the pharma& Patient Assistance Program and its administrators ("the Program") to contact my health care providers, pharmacies, and health insurers in order to obtain information about my health and to verify my insurance benefits. I authorize my health care providers, pharmacies, service providers, health insurers and their contractors to disclose my personal information, including information about my insurance coverage, prescriptions, medical conditions, and health. I authorize and instruct the Program to obtain a consumer report on me pursuant to the Fair Credit Reporting Act that will be used to estimate my income as a part of the eligibility determination process. I acknowledge that the Program may request additional documentation to verify my personal information. If there is missing information and I do not respond to requests for additional documentation, it may delay my participation or eliminate me from participating in the Program. I give permission to the Program to disclose my personal information to my health care providers and zr pharma& GmbH and its affiliates for the purpose of carrying out Program operations and for internal business operations and quality assurance purposes. I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law and applicable state law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time by contacting the Program at 1-855-443-7028. If I qualify for product from the Program, I agree that I will not get reimbursed for it from anyone else, including my insurance. I understand that I must re-apply for assistance at the end of my eligibility period in order to qualify for further assistance. I agree that I will immediately notify the Program of any changes to my insurance or financial situation by contacting the Program at 1-855-443-7028. I certify that I understand that the pharma& Patient Assistance Program is intended to provide temporary support and may be discontinued at any time for any reason with or without notice, including changes made to the rules for participation. I have read this authorization and agree to its terms.

PATIENT/REPRESENTATIVE'S SIGNATURE _____Date_____
Personal Representative's Name and Relationship_____

pharma&

pharma& Patient Assistance Program Enrollment Form
PO Box 14852 ◆ Lenexa, KS 66285
Phone: 855-443-7028 ◆ Fax: 833-313-8348
Monday – Friday, 9:00am – 6:00pm ET

PAGE TO BE COMPLETED BY PROVIDER AND FAXED TO 833-313-8348

PROVIDER INFORMATION

Provider Name _____ NPI _____

PTAN _____ State License _____ Medicaid # _____

Facility Name _____ Tax ID _____

Street Address _____

City _____ State _____ Zip _____

Facility Contact _____ Title _____

Contact Phone/Ext _____ Contact Fax _____

SHIPPING INFORMATION

Once the eligibility determination is made and the patient is approved for free product, the Program will contact the entity chosen below for shipment date and details.

❑ Ship to Patient ❑ Ship to Physician

TREATMENT INFORMATION

Patient Name _____ Date of Birth _____

Known drug allergies (REQUIRED) ❑ None ❑ Attached ❑ Allergies: _____

Concurrent medications (REQUIRED) ❑ None ❑ Attached ❑ Medications: _____

PRIMARY ICD-10 Code _____ Description _____

Medication	Quantity	Frequency/Directions	Dispense Amount	Refills
PEGASYS® 180 mcg/mL VIAL (peginerferon alpha-2A)			❑ 30 days ❑ _____	❑ 1 year ❑ _____

NY State Prescribers must also submit an ePrescription or phone in the prescription

❑ **Electronic Prescription (eRX) Submitted** Medvantx NPI Number: 1073692745 NCPDP number: 4351968

By signing below, I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed the product listed above based on my professional judgment of medical necessity. I certify that I have received the necessary written HIPAA authorization from the above-named patient to release the medical and/or patient information relating to the free product to pharma& Patient Assistance Program and its representatives for the purpose of determining eligibility for free drug. I also authorize pharma& Patient Assistance Program and its representatives to perform any necessary steps, including but not limited to insurance verification and case assessment in order to determine eligibility for the Program. I understand that additional information may be required, and I agree to provide it as needed. I certify that I have not received, nor will I seek or accept reimbursement for any drug provided to my patient via the pharma& Patient Assistance Program. I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this Program, and I will notify pharma& Patient Assistance Program if I become aware of any such changes.

I have prescribed the medicine indicated above for the referenced patient.

PROVIDER SIGNATURE (original, no stamps)_____**Date**_____