LeukineDirect®
PATIENT ENROLLMENT FORM

PTx PARTNER THERAPEUTICS®

LeukineDirect
PO Box 501848,San Diego, CA 92150-1848

Phone: 877-3LEUKINE (877-353-8546) **Fax:** 855-881-6864
Hours: Monday through Friday, 9:00 am – 5:00 pm Eastern Time

SERVICE(S) REQUESTED

Check all that apply: ☐ Benefits Verification ☐ Prior Authorization/Appeals Assistance ☐ Copay Assistance (Leukine® Partner Program) ☐ Claim Support

APPLICATION CHECKLIST (Research will be delayed if all information is not received)

Confirm all are completed: ☐ Prescriber Signature AND ☐ Patient Signature ☐ All required sections

PRESCRIBER INFORMATION (required)

Physician Name:		Specialty:	
Physician Address:	City:	State:	Zip:
Physician Tax ID# :		Physician NPI#:	

FACILITY INFORMATION (required)

Facility Name:	Facility NPI:	Facility Tax ID #:	
Facility Address:			
City:	State:	Zip:	
Facility Setting: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Home Infusion ☐ Other – Please specify:			
Contact Name:	Contact Email:		
Contact Phone #:	(Extension)	Contact Fax #:	

PREFERRED METHOD OF CONTACT

What is your preferred method to receive program communication? ☐ Fax ☐ Email (If checked, please provide email address:_____
Please note: All communication is sent via fax if this is not checked**

BILLING INFORMATION FOR COPAY ASSISTANCE (Reimbursement checks will be mailed to the address below)

Same as the facility information above: ☐ Yes ☐ No (if No, please complete all the sections below)			
Facility Name:			
Facility Billing Address:			
City:	State:	Zip:	
Contact/Department Name:		Contact Phone #:	
Check Made Payable To (required):			

PATIENT INFORMATION (required)

Patient Name:	Date of Birth:	SSN/ID# (last 4 digits):	
Phone#:	US Resident? ☐ Yes ☐ No	Gender ☐ M ☐ F	
Patient Address:	City:	State :	Zip:

PATIENT INSURANCE INFORMATION (required) (Attach a copy of insurance cards, if available).

Primary Insurance:	Policy#:	Group #:
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:
Secondary Insurance:	Policy#:	Group #:
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:

DOSAGE INFORMATION (required)

Drug:	**Dosage:**	**ICD- 10 Primary Diagnosis Code:**	**ICD- 10 Secondary Diagnosis Code:**	**Date of Service:**
Leukine® (sargramostim) 250 mcg vial				

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LeukineDirect Reimbursement Hotline
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PRESCRIBING CLINICIAN CERTIFICATION AND CONSENT

By signing below, I am certifying that the information contained in this form is complete and accurate to the best of my knowledge. My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive, and administer the requested medication(s) listed on this enrollment form. I understand that Partner Therapeutics, Inc. reserves the right to modify or terminate LeukineDirect at any time and without notice. I understand that Partner Therapeutics is not responsible for filing claims and that the information provided by LeukineDirect is for general reference and informational purposes only and is based on my patient's health plan and payer guidelines. I also understand that verification of insurance coverage is ultimately my responsibility as the healthcare provider and that reimbursement by payers is subject to many factors. Partner Therapeutics, through LeukineDirect, does not represent or guarantee that payer reimbursement or any other payment or reimbursement of any kind will be made. I understand that Partner Therapeutics does not reimburse for claims denied by payers.

All final decisions on diagnosis, the need for treatment, and the appropriateness of Leukine® (sargramostim) for a particular patient rest with me as the patient's healthcare provider. I understand that I am under no obligation to prescribe any Partner Therapeutics drug and I have not received and will not receive any benefit from Partner Therapeutics for prescribing a Partner Therapeutics drug. I further verify that I have the required authorizations, including a valid and completed HIPAA Authorization form, from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to LeukineDirect. By completing and signing this form, I agree to be contacted by Partner Therapeutics and companies working with them, by mail, fax, e-mail, or telephone for the purposes of managing and delivering services through the LeukineDirect program. I may withdraw my request for LeukineDirect services at any time by calling 877-353-8546.

Prescribing Clinician Name (print):

Prescribing Clinician Signature:
(no stamped signatures)

Date:

PATIENT CERTIFICATION AND AUTHORIZATION

I understand that LeukineDirect is a product access program that offers eligible patients services relating to benefits verification, copay assistance, claims support and prior authorization/appeals assistance. I attest that the information in this form is true, correct, and complete, and I understand that LeukineDirect ("the Program") assistance will terminate if the Program becomes aware of any fraud or if Leukine ® (sargramostim) is no longer prescribed to me. I understand that in order for the Program to provide me with assistance, it will need to obtain, review, use, and disclose information related to my personal health, including information related to my medical records and history, medications, medical conditions and treatment, health insurance coverage and the personal information on this enrollment form including my name, address, telephone number, social security number, insurance plan and/or group numbers (together, "Protected Health Information").

By signing this form, I authorize my treating doctor, my employer, and my health insurer to give people who work for and with Partner Therapeutics, including its business partners and agents ("Partner Therapeutics"), my Protected Health Information. I also superficially authorize Partner Therapeutics to receive, use and disclose my Protected Health Information for the following purposes: (i) to enroll me in, and contact me and/or the Patient Representative I identify below ("Patient Representative"), about LeukineDirect programs, including potential enrollment in the copay assistance program if I am eligible; (ii) to help verify, investigate, assist with or coordinate insurance coverage for Leukine or to obtain payment or other support for Leukine; (iii) to coordinate my prescription fulfillment; (iv) to provide me and/or my Patient Representative with educational materials, information and services related to Leukine; and (v) to assist with analyses related to the quality, efficacy and safety of Leukine, including patient access and treatment compliance. In carrying out these activities, Partner Therapeutics may share information about me with my doctor, my employer, my health insurer, my pharmacy and/or pharmacists, and independent third-party patient assistance foundations. Third parties may receive payment from Partner Therapeutics to provide the services associated with the Program. I understand that my Protected Health Information will not be used or disclosed by Partner Therapeutics for any other purpose than described in this form unless permitted by law or unless information that specifically identifies me is removed and therefore is "de-identified." I also understand that Partner Therapeutics will make every effort to keep my information private but that information used or disclosed under this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

This Authorization is valid for two (2) years from the date of my signature or until I am no longer participating in the Program, whichever is sooner. I understand that Partner Therapeutics has the right to change or end the Program at any time without prior notification to me. I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits. I further understand that I may revoke this Authorization at any time by contacting the Program in writing at the address above that includes my name, date of birth, address and date of revocation. The revocation will not apply to any information already used or disclosed pursuant to this Authorization. If I do not sign this form, or cancel (revoke) my Authorization later, I understand that this means that I will not be able to participate or receive assistance from LeukineDirect.

I permit Partner Therapeutics to speak with my Patient Representative about the information on this form and the status of my request. I understand that I have the right to see or copy the Protected Health Information my healthcare providers or insurers have given to Partner Therapeutics.

Patient Name (print): Date of Birth:

Patient Signature: 

Date:

Patient Representative Name (print): Relationship to Patient:

Patient Representative Signature: Date: