LeukineDirect[®] PATIENT ASSISTANCE PROGRAM APPLICATION



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Provider AND Patient signature required

All information in required fields

Proof of Income (includes, but not limited to: 1040 form, Social Security Retirement and Supplemental Social Security Income, SSA

1099 from previous year, Unemployment award letter)

PRESCRIBER INFORMATION (required) Physician Name: Specialty: Physician Address: City: State: Zip: Physician Tax ID# : Physician NPI#: Issuing State: DEA# : Physician State License#: FACILITY INFORMATION (required) Facility NPI: Facility Tax ID #: Facility Name : Facility Address: City: State: Zip Code: 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** **PATIENT INFORMATION** (required) Patient Name: Date of Birth: SSN/ID# (last 4 digits): Phone#: US Resident? Ves No Gender M F Patient Address: State : City: Zip Code: PATIENT INSURANCE INFORMATION (Attach a copy of insurance cards, if available). CHECK HERE IF UNINSURED Primary Insurance: Policy#: Group #: Policy Holder's Name: Policy Holder's Date of Birth: Payer Phone #: Group #: Secondary Insurance: Policy#: Payer Phone #: Policy Holder's Name: Policy Holder's Date of Birth: **PRESCRIPTION INFORMATION** (required) Quantity: Indicate Number of Cartons per Month **Refills:** ICD 10 Diagnosis: Drug: (1 Carton = 5 vials) Leukine® (sargramostim) 250 mcg vial SIG: Height: Weight: Allergies: Х Sign Here Prescribing Clinician's original signature (no stamped signatures) Date

PRESCRIBING CLINICIAN CERTIFICATION AND CONSENT (required)

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 application 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 advisory in nature. 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 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. If my patient participates in the Patient Assistance Program, I certify that I will not charge the patient or submit a claim to any third party for services related to my patient's Leukine therapy. I understand that any product provided under the Patient Assistance Program must only be used for the approved patient and may not be sold, traded, or returned for credit.

Prescribing Clinician Name (print):

Prescribing Clinician Signature (no stamped signatures):

Date:

PATIENT ASSISTANCE (certification and aut	horization to disclose information) (required)
Patient Name:	Date of Birth:
Patient's Total Annual Household Income: \$ (Attach the most current copies of income documentation Checklist Section.)	Household Size (including patient): on for you and all dependent persons. See list of documents below in the Application
Ship to Name:	
Ship to Facility Name (if applicable):	
Ship to Address:	
City:	State: Zip Code:
Ship to Contact Phone Number:	(Extension)
verification, claims support, prior authorization/apper application for the Program's Patient Assistance Pro- information in this application is true, correct, and comple becomes aware of any fraud or if Leukine [®] (sargramostii information on this application form change, including if I reimburse for Leukine [®] (sargramostim). I understand that understand that in order for the Program to provide me w personal health, including information related to my medi form.By signing this form, I authorize my treating doctor, Therapeutics, including its business partners and agents Therapeutics may use my information to help verify or co carrying out these activities, Partner Therapeutics may sl- independent third-party patient assistance foundations. T associated with the Program.I understand that once my h regarding patient privacy. I understand that once my h regarding patient privacy. I understand that my consent la Partner Therapeutics has the right to change or end the F this form and that doing so will not affect my doctor's treat this Authorization at any time by contacting the Program revocation will not apply to any information already used cancel my authorization, I will not be eligible for the Program	patient support program that offers eligible patients services relating to benefits als assistance and medication costs. By filling out this form, I am submitting an gram, which helps eligible patients with the costs of Leukine. I attest that the tet, and understand that any assistance offered by the Program will terminate if the Program m) is no longer prescribed to me. I agree to update the Program should any of the become eligible for any benefit through a federal, state, or private program, which may changes in my health insurance coverage may impact my eligibility for the Program. I also it hassistance, it will need to obtain, review, use, and disclose information related to my cations, medical conditions and the personal and financial information on my application my employer, and my health insurer to give people who work for and with Partner ("Partner Therapeutics"), information about my insurance and my health. Partner ordinate insurance coverage or to obtain payment or other support for mytreatment. In hare information about me with my doctor, my employer, my health insurer, and hird parties may receive payment from Partner Therapeutics to provide the services health information is disclosed it may no longer be protected by federal or state law asts for one (1) year from the date that I am approved into the Program. I understand that Program at any time without prior notification to me. I understand that I may refuse to sign timent of me or my eligibility for insurance benefits. I further understand that I may revoke in writing that includes my name, date of birth, address and date of revocation. The or disclosed pursuant to this Authorization. I understand if I do not sign, refuse to sign, or ram. I give consent to my physician or facility to receive medication on my behalf to be peutics, Inc. to speak with the Patient Representative named below about the information st. This includes discussing insurance and financial questions, any missing documentation
Patient Name (print):	Date of Birth:
Patient Signature:	Sion Here Date:
Patient Representative Name (print):	Relationship to Patient:
Patient Representative Signature:	Date:
PATIENT ASSISTANCE PROGRAM DISCLAI	MER: Partners Therapeutics reserves the right to request additional