TOBI FOUNDATION

"INCREASING ACCESS TO CARE FOR PATIENTS AND FAMILIES"

# PATIENT APPLICATION

## PATIENT INFORMATION:

Patient Name:_____ Patient Social Security No.:_____ DOB:_____
Street Address:_____ City:_____ State:_____ ZIP:_____
Contact Name:_____ Contact Primary Phone:_____
Relationship:_____ Secondary Phone:_____

## HEALTH PLAN INFORMATION:

Primary Medical Health Plan:_____ Phone Number:_____
Policy ID Number:_____ Group Number:_____
Subscribers Name:_____ Subscriber's DOB:_____ Relation to Pt:_____

Pharmacy Benefit Card Name (Drug Card):_____ RxBin:_____
ID Number:_____ Group ID:_____

To your knowledge does your medical health plan cover TOBI®?: YES N O

To your knowledge does your pharmacy benefit card cover TOBI®?: YES NO

**Co-pay for TOBI®: $_____, or if percentage Co-pay _____%**

If applicable: Deductible Amount: $_____, covered at _____% after Deductible.

Out-of-Pocket max of $_____, then covered at _____%.

Is there a secondary health plan? YES NO

Is the Patient a beneficiary of: Medicare Medicaid ID Number:_____

## PUBLIC PROGRAMS:

Has the patient applied for assistance through Medicaid or other any other public healthcare program?: YES NO

If YES, Date of Application:_____ Program Name:_____

Status of Application: Approved Pending Denied

If NO, please give reason why application was not made?_____

_____

## FINANCIAL AND OTHER INFORMATION:

Size of Family:_____
(A family is defined as ALL individuals in a single household, whether or not related by blood or marriage, including dependant children that may be residing in another location if they are attending school full time.)

Household Income (as reported on most recent 1040 Tax Returns filed by all household members): $_____

Other Income (income not reported on Family/or Individual Tax Returns:) $_____

Source of other income (ie. Social Security Benefits, Child Support Received):_____

Patient/Family Out-of-Pocket Expenses:

Annual Medical Expenses NOT Reimbursed by any health plan: $_____
Total College Tuition Expenses: $_____
Child Support Paid: $_____

If the patient/family's annual income has changed significantly from the amount reported above, please attach an explanation.

**DOCUMENTATION:**

Please submit the following Documentation to support the information listed on the application:

**Income Verification**

Required documentation:

- Copy of the most recent IRS Tax Returns (1040, 1040A, or 1040EZ) for ALL members of the household.
  Note: W-2 forms will not suffice as proof of income level, it must be the actual IRS Tax Return.

Submit only if applicable:

- Statement of Social Security Benefits received (IE: Award Letter, Check, or recent Bank Statement indicating monthly benefit amount.)
- Statement of short and/or long term disability benefits.
- Statement of alimony and/or child support received.
- Statement of unemployment benefits.
- Statement of any other public assistance benefits.
- Documentation of any other sources of income not included in tax returns and not listed above.

Information included in the sections of the Application Form titled "Financial and Other Information" and "Public Programs" section is subject to verification. If for any reason the Foundation deems it necessary to verify or audit your application, you may be required to produce the following documentation:

- IRS Schedule A (or other documentation to support unreimbursed medical expenses.)
- College tuition bills or other statements showing tuition expense, any financial aide received, and family responsibility.
- Court order for child support payments.
- Denial letter from Medicaid or other public healthcare programs.

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**ATTESTATION:**

**I am applying to the TOBI® Foundation for assistance in paying for TOBI® for treatment of Cystic Fibrosis. I attest that the information provided in this application is complete and accurate. I understand that the TOBI® Foundation may request additional documentation relating to my family income and my insurance coverage. I understand that all information I provide may be verified by an audit by the TOBI® Foundation or its representative. I understand that any eligibility for assistance will end if:**

- **The TOBI® Foundation becomes aware that false or inaccurate information was provided as part of the application process.**
- **The TOBI® Foundation becomes aware of any fraudulent activity relating to the assistance provided by the TOBI® Foundation. TOBI® Foundation assistance is provided for the sole benefit of the patient named on the Application.**
- **TOBI® is no longer prescribed to the patient.**

**I understand that the TOBI® Foundation reserves the right at any time, or for any reason, and without notice to: 1) modify the Application process, 2) modify or discontinue the assistance program and the related eligibility criteria, or 3) terminate assistance.**

**Patient or Guardian Signature:**_____ **Date:**_____

**Please return this completed form to:**

**TOBI® Foundation**
**250 Technology Park**
**Lake Mary, FL 32746**

**If you have any questions about this form or the evaluation process, please call The TOBI® Foundation at:**
**Phone 877-862-4423**
**For immediate consideration, please feel free to fax the information (in addition to mailing the originals) to:**
**Fax 866-899-8624**

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# Patient's Physician Information

Dear Physician:

The patient listed below is applying for assistance from the TOBI® Foundation. To be eligible for assistance, the patient must have a confirmed diagnosis of cystic fibrosis with *P. aeruginosa* infection and must be prescribed TOBI® (tobramycin solution for inhalation). Please complete the brief attestation form below to assist in the TOBI® Foundation's determination of patent eligibility. If your have any questions about the application or application process, please consult our website at www.tobifoundation.org or call the TOBI® Foundation at 1-877-TOBI-4CF (862-4423). Thank you for your assistance.

**Patient Name:**_____ **Patient's SS#:**_____

Contact Name:_____ Phone Number:_____

## Physician Information

MD Name:_____ Office Contact Name:_____

DEA #: _____ UPIN Nbr:_____

State Licensure Nbr:_____ Exp Date:_____

Address:_____ Phone:_____

_____ Fax:_____

City:_____ State:_____ Zip:_____

### Diagnosis Attestation

I certify that the patient listed above has a confirmed diagnosis of cystic fibrosis with *P. aeruginosa* infection. I also certify that therapy with TOBI® is medically indicated for this patient, and I have prescribed TOBI®for treatment of this patient.

**Physician Signature:** **Date:**

**Please return this completed form to:**

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**250 Technology Park**
**Lake Mary, FL 32746**
**Phone: 877-862-4423**
**Fax: 866-899-8624**

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# Patient Certification And Authorization to Release Information

**Patient Name:** _____

I understand that in order for me to be evaluated for or receive assistance from the TOBI® Foundation, the TOBI® Foundation needs certain information about my medical diagnosis and treatment, my health insurance, and my family income. I authorize my health care providers and my insurance companies to disclose to the TOBI® Foundation and its employees, third party administrators, agents and other representatives, information about me, my current medical condition, and my health insurance coverage.

I understand that the TOBI® Foundation may provide de-identified, aggregate data about myself and others in reports to the Chiron Corporation ("Chiron"), which is the manufacturer of TOBI® and which is contributing funds to the TOBI® Foundation to support its charitable purpose, so that Chiron can better understand the operation of the program and how the funds it has contributed are being used. I understand that information about me that is being kept by the Foundation, including health information, may be periodically reviewed by an independent auditor for purposes of monitoring the program. However, I further understand that any report issued by the auditor will not identify me by name. I understand that the TOBI® Foundation may release information about me to the pharmacy that receives my TOBI® assistance vouchers and provides me with TOBI®. I also understand that pharmacies receiving vouchers may release information about me to the TOBI® Foundation to facilitate voucher redemption.

I understand that I may revoke (end) this authorization at any time by mailing or faxing a signed letter of revocation to the TOBI® Foundation at the address or fax number below, but that if I revoke this authorization I will no longer be eligible for assistance from the Foundation. I further understand that information collected about me prior to my revocation may still be used and reviewed by the TOBI® Foundation and an auditor of the Foundation for purposes of administering and monitoring the program.

I hereby certify that all written and verbal information that I have provided to the TOBI® Foundation is accurate, and that if there are material changes to that information I will notify the TOBI® Foundation as soon as practical.

I understand that the Foundation is wholly dependent on donated funds. If the funding is reduced or stopped, the Foundation may have to reduce or stop the financial assistance provided. I understand that because the Foundation has a responsibility to be cost effective, I am being asked to use all other available assistance programs prior to or in conjunction with Foundation financial assistance.

This certification and authorization expires one year from the date I sign it. I understand that I will receive a copy of this form after I sign it.

**Patient**
**(Or Guardian)**
**Signature:** **Date:**

Please return this completed form to:
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Lake Mary, FL 32746
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Fax: 866-899-8624