Please call 1-866-742-7646
with any program questions.

Patient Assistance Program
ENROLLMENT APPLICATION

Please FAX Completed Application to:
1-866-369-4333

SECTION 1 To Be Completed By Patient or Legal Guardian

Patient's Name: ____________________ New Application Renewal Application

Address:____________________ Telephone #:(________) ____________________

City:____________________ State:____________ Zip:________________

Social Security number (optional): _________ - _________ - _________

Date of Birth: _______/_______/_______

Sex: M____ F____

U.S. Resident: YES_______ NO_______

Primary Insurance Name:____________________ Phone:________________ Subscriber ID #:________________

Subscriber:____________________ DOB:________________ Policy/Group #:________________

Secondary Insurance Name:____________________ Phone:________________ Subscriber ID #:________________

Subscriber:____________________ DOB:________________ Policy/Group #:________________

Please indicate YES or NO if you are eligible for any of the following:

Prescription medication benefits YES_______ NO_______

Veterans' Administration YES_______ NO_______

Disability YES_______ NO_______

Medicare YES_______ NO_______

Medicaid YES_______ NO_______

Total household monthly income before taxes (include all income, wages, social security, pension, disability, interest earned on savings, etc.): $____________
I agree to provide additional documentation upon request to verify the information above including bank statements and W-2 forms.

Number of persons (including yourself) dependent upon household income within family. ______________

I attest that the above information is correct and complete. I authorize Pharmion Corporation and/or its representative to contact my insurer, other potential city, state, county, or federal funding sources, social workers or patient advocacy organizations on my behalf to determine my eligibility for alternative health insurance coverage/funding. I authorize my insurance company, prepayment organization, employer, hospital, physician, dispensing agent or any other healthcare provider to release to Pharmion Corporation and/or their representatives all medical records, medical information regarding my medical condition, treatment, drug therapy and information which may have a bearing on the benefit payable under any plan providing benefits or services, including the dollar balance of benefits remaining under any applicable lifetime maximum benefits provision or which may have a bearing on my medical condition. I authorize Pharmion Corporation and/or its representatives to use this information solely to determine my eligibility for this Patient Assistance Program and to administer the program, and I understand that Pharmion may not be able to determine my eligibility without this authorization. Pharmion Corporation and/or its representatives agree not to disclose any information obtained from these sources to any third party except as required by applicable law. This authorization expires when (a) Pharmion determines I am not eligible to participate in the Patient Assistance Program or (b) my participation in the Patient Assistance Program ends, whichever is earlier. I understand that I have the right to revoke this authorization at any time by providing written notice to Pharmion Corporation.

______________________________ ________________
Patient's or Legal Guardian's Signature Date

SECTION 2 To Be Completed By Prescribing Physician

Physician's Name:____________________ Physician UPIN:________________ State License:________________

Address:____

City:____________________ State:______________ Zip:____________________

Telephone #:(________) ____________________ Fax #:(________) ____________________

Name of Prescribed Drug: ____**Innohep® (tinzaparin sodium injection)**______ Days of Therapy:______________ Body Weight (kg):________

Dosage Regimen:____

Diagnosis/ICD9:____

Delivery Information: All approved product will be shipped to the Physician's Address above.

Saturday Delivery (check one): Yes, receipt of Saturday delivery is available. No, receipt of Saturday delivery is not available.

Monday through Thursday
- All completed and approved applications received before 2:00 EST will be processed and drug will be delivered within the next business day.
- All completed and approved applications received after 2:00 EST will be processed and drug will be delivered within 2 business days.

Friday
- All completed and approved applications received before 2:00 EST on Friday and if Saturday delivery is available, drug will be delivered on Saturday. If Saturday delivery is not available, drug will be delivered on the following Tuesday.
- All completed and approved applications received after 2:00 EST on Friday will be processed and drug will be delivered on the following Tuesday.

I certify that all of the above statements and information provided are correct. I certify that I have read and understand the information on the reverse side and agree to provide the specified material upon request. I authorize Pharmion Corporation or its designee to audit PAP records to insure the program and its criteria are being met. I understand that continued eligibility under this program is subject to Pharmion Corporation's approval.

______________________________ ________________
Physician's Signature Date

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2002149

As a means of assisting those patients who cannot afford to purchase our products, Pharmion Corporation has created a Patient Assistance Program (PAP). Enrollment is offered to eligible patients who do not qualify for government assistance or have third party insurance coverage and are financially unable to pay for the product.

SECTION 1 Patient (or Legal Guardian)

Please complete the Enrollment Application on the reverse side. Form will be returned if information is incomplete. Incomplete forms will delay the enrollment review process.

Alternate Sources of Funding:

Please indicate whether or not you (the applicant) are eligible for Medicare, Medicaid, prescription medication insurance, Veterans Assistance, or disability.

Gross Monthly Household Income:

Please provide your total household MONTHLY income before taxes. Include income from salary/wages/dividends, social security, disability, unemployment compensation, pension/annuity. Please be sure to include monthly income of all household members. You agree to provide additional material (bank statement and W-2) upon request to verify the information on the reverse side.

Signature and Date:

You, or your legal guardian, must sign and date the Application, attesting that the information provided is both complete and accurate.

All information contained in this application will be kept confidential as required by law and regulation.

SECTION 2 To Be Completed By Prescribing Physician

Please collect all information needed to complete the application on the reverse side. Once all the information is gathered, please sign and date the form. Fax the completed application to the Innohep® Patient Assistance and Reimbursement Program to: 866-369-4333. Please call 866-Pharmion (866-742-7646) if you have questions or need assistance. Pharmion Corporation reserves the right to change the provisions of this program and to change or remove products available through this program at any time.

Innohep® Patient Assistance & Reimbursement Resources

Questions or Need Assistance

Call 866-Pharmion (866-742-7646)

Please Fax Completed Application to:

866-369-4333