THE MEDICINES COMPANY

Angiomax®
(bivalirudin)
FOR INJECTION

THE MEDICINES COMPANY PATIENT FINANCIAL ASSISTANCE PROGRAM

October 1 2011

Dear Healthcare Provider;

Thank you for your interest in THE MEDICINES COMPANY (MDCO) HOSPITAL/PATIENT ASSISTANCE PROGRAM (PAP) for **ANGIOMAX®.** Attached is THE MEDICINES COMPANY PAP application to be completed and signed by you. To facilitate this process, refer to the application instructions and be sure to complete all sections. Return the application by faxing it to THE MEDICINES COMPANY at 1-800-759-4491.

The completed application will be evaluated by THE MEDICINES COMPANY PAP staff. You will be notified of the patient's eligibility via fax. Please note THE MEDICINES COMPANY PAP program is only available to uninsured and uninsurable patients and any product provided via THE MEDICINES COMPANY PAP is not eligible for billing to any private, federal or state healthcare program or the patient.

If you have questions, please call THE MEDICINES COMPANY PAP staff at 1-800-756-6463. Analysts are available to assist from 9:00 to 6:00 EST. Feel free to leave a message after hours and your call will be returned on the next business day.

Please be advised that THE MEDICINES COMPANY PAP will be converting from a credit program to a product replenishment program. There are various changes to this application and to the product replenishment eligibility.

While THE MEDICINES COMPANY will make every effort to grant aid for requests that satisfy the eligibility criteria, this program is limited to available resources and may be discontinued or revised at any time.

Sincerely,
THE MEDICINES COMPANY
HOSPITAL/PATIENT ASSISTANCE PROGRAM
Attachment: MDCO PAP Application

THE MEDICINES COMPANY PAP APPLICATION

To be completed by the Healthcare Provider (see instructions on Page 3).

THE MEDICINES COMPANY HOSPITAL/PATIENT ASSISTANCE PROGRAM offers Product Replenishment for **ANGIOMAX®** (bivalirudin) for eligible patients at no charge. Applications for such assistance will be considered on the basis of need as certified by the attending physician or appropriate healthcare provider. THE MEDICINES COMPANY PAP is available to uninsured and uninsurable patients. Any products provided via THE MEDICINES COMPANY PAP will not be billed to any private, federal or state healthcare program or the patient. Acceptance of this aid constitutes an authorization to release the information on this form to THE MEDICINES COMPANY. THE MEDICINES COMPANY will make a diligent effort to keep all information confidential and will use it only for the assistance of the administration of this program.

Patient Information:

Patient Name: Phone:

Street Address:

City/State/Zip:

Product Requested: ☐ **ANGIOMAX®**		
Patient Birth Date:	Patient Weight:	Hospital Account Number:
Is Patient a US Resident? ☐ Yes ☐ No If Yes, Social Security #:	# of People in the Household:	
Gross MONTHLY income of patient $		
Does your patient have any medical or prescription insurance?	☐ Yes ☐ No	
Have you attached proof that patient is not eligible for coverage under Medicaid?	☐ Yes ☐ No	
Has third party payment been made for any portion of the required procedure?	☐ Yes ☐ No	
Date therapy initiated:	Duration of therapy (in hours):	
Number of vials of **ANGIOMAX®** (bivalirudin) used for this patient:		
Treatment ICD-9 Code	Description	
Procedure ICD-9 code	Description	

Attending Physician:

Physician Name: Phone:

Street Address:

City, State, Zip:

Physician's DEA number: Physician's ME number:

Institution:

PLEASE INCLUDE ADDRESS AND PHARMACY LICENSE NUMBER FOR PRODUCT REPLENISHMENT

Name of Institution: Phone:

Street Address: PHARMACY LICENSE NUMBER

City, State, Zip: Facility DEA #:

THE MEDICINES COMPANY PAP APPLICATION

To be completed by the Healthcare Provider (see instructions on Page 3).

Institution Information Continued:

GPO (Group Purchasing Organization):

Wholesaler Name

Wholesaler Complete Address:

Wholesaler phone number:

Wholesaler Account Number:

Amount Paid for **ANGIOMAX®:** **(per vial)**

Healthcare Provider Information: (required if application signed by Healthcare Provider)

Name of Healthcare Provider: Phone:

Street Address:

City, State, Zip:

I certify to the best of my ability that the information above is accurate and complete and the above patient has financial need. I have received consent from the patient or the patient's guardian to enroll the patient in THE MEDICINES COMPANY PAP and I agree to allow THE MEDICINES COMPANY, or an authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the data to THE MEDICINES COMPANY's authorized representative. I further represent that this patient has no prescription insurance coverage for the applied for drug, including all public programs. My signature certifies that no other submissions for payment for product(s) provided under the program will be made to any private, federal or state healthcare program or the patient.

______________________________ ______________________________

Healthcare Provider Signature Date

Authorized Institution Signature: ______________________________ ______________________________

Please Sign Name *Please Print Name*

Hospital Contact Person: ______________________________ ______________________________

Please Sign Name *Please Print Name*

Department: ______________________________ **Fax:** (_____)______________________________

Phone: (_____)______________________________ **Date:** ______________________________

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THE MEDICINES COMPANY PAP APPLICATION INSTRUCTIONS

Patient criteria:

- **Must** be US Resident *(if requested, must be able to provide copy of W-9)*
- **Must** meet financial criteria (not published)
- **Must not** have any private insurance that would cover the product(s) offered under this program
- **Must not** be eligible for Medicaid or Medicare *(written proof is required)*

Facility / HealthCare provider responsibilities:

- Application **must be** submitted with required signature of the Institution and authorized Institution Contact
- All applications must meet the following requirements:
  - All applications submitted on or after January 31 2011 must be submitted on the application with a form revision date of 2011. All applications received under older form versions will be returned as unprocessable.
  - All application questions and checkboxes **must** have a valid response or application will be returned as unprocessable.
  - Date(s) of treatment cannot be greater than 6 months from the date the application was submitted.
  - All applications must be submitted with proof of product(s) dispense from Institution pharmacy and proof that patient received the product(s) covered by this program. Documentation to support this request includes but is not limited to the following document type/format: Pharmacy dispensing log, operative report, case synopsis, etc.

Diagnosis

- The diagnosis must reflect the reason for treatment and must be submitted in a valid billing ICD9 format along with a valid descriptor and procedure ICD9 code. All applications must be submitted with both a valid treatment ICD9 code **and** a valid procedure ICD9 code.

All applications submitted with invalid billing ICD-9 codes, improper treatment ICD-9s and/or improper procedure ICD-9s will be returned as denied for not meeting the medical criteria for the program. We recommend that you confirm with your internal coding department if you should have questions regarding the proper use of the product(s) provided via The Medicine's Company PAP Program.

Medicare and/or Medicaid

- Patient must not be eligible for Medicare or Medicaid. All applications must be submitted with a written eligibility denial letter or written non-eligible letter indicating the specific reason(s) the patient is ineligible under these programs.

Gross Monthly income

- Gross income **must be** reported by month (Gross monthly income includes but is not limited to: unemployment, disability, Social Security, child support, alimony, pension benefits, etc.)
  - If reporting monthly income, the application **must be** submitted with a copy of the previous year's tax return documents (1040, 1040A, or 1099), or W2s.
- For patients with a reported monthly income of $0 (zero), the application must be submitted with 3 current consecutive months of bank statements.

If this documentation is not available to support the income reported by the patient, the Institution or authorized Institution Contact ***must*** *submit a* ***notarized*** *letter providing the reason(s) these documents may not be available for review under the program. All applications received without the supporting documentation required will be reviewed on a case by case basis.*

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