The Factor Plus℠ Program is a product replacement program for eligible Hemophilia A patients.

Eligibility Requirements

At the time of enrollment, a patient must be medically and financially needy. Patients must NOT be eligible for: any private third party insurance coverage; any public programs such as Medicaid, Medicare, SSI, state assistance programs or high risk pools; the Baxter Factor Assist™ program; or any other assistance program. Patients must not have the financial resources to pay for the product. Medical information, financial documentation and written proof of insurance denial may be required for enrollment. Patients must be U.S. citizens or permanent residents of the United States. Proof of citizenship is required.

Each approved patient will be eligible for a maximum amount of replacement product based on the patient's historical average annual usage not to exceed 80,000 units per 12 months.

Patient Enrollment

Enrollment requires the completion of three forms:

1. Form A - Provider Certification and Consent - must be completed by the provider
2. Form B - Patient Application - must be completed by the patient, parent or guardian
3. Form C - Physician Certification and Consent - must be completed by the physician

If approved, initial enrollment will be granted for 3 months. At the end of 3 months, an assessment of continued need will be undertaken by the Factor Plus℠ Program administrator. Enrollment can be extended for up to 1 year after which the patient will be withdrawn from or re-enrolled into the Factor Plus℠ Program.

Replacement of Product

If a Factor Plus℠ patient has received Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH, Baxter Healthcare Corporation will replace this product. The patient's provider may submit a product replacement request form (Form D) throughout the month but no later than the 20th of the next month. For example, for product used in January, a product replacement form (Form D) no later than February 20th. No retroactive coverage will be allowed. Requests for product replacement received after the 20th of the month will not be approved. Prescriptions must be attached to all product replacement forms.

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FACTOR PLUS^{SM} Program

Provider Enrollment Application

Providers must submit this form to enroll in the Factor Plus^{SM} Program.

Please submit one time only. Send completed form to:

The Factor Plus^{SM} Program
c/o InTeleCenter™
P.O. Box 4280
Gaithersburg, MD 20885-4280
Fax Number: 240-632-3807

Date submitted: ______________________

Provider Information

Baxter customer number: A ______________________

Provider name: ______________________

Provider contact person: ______________________

Title: ______________________

Mailing address:

____

____

Phone number: (   ) __________ Fax number: (   ) __________

Shipping Address (if different from mailing address above):

____

____

If you have any questions about the Factor Plus^{SM} Program, please call 800.548.4448 (Option 2)

Please see back of form for Enrollment and Eligibility Information

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Form A

FACTOR PLUS℠ Program

Provider Certification and Consent

By signing and submitting this form, I agree to the following on behalf of ____________________.
(patient's name)

I confirm that ______________________________ will be furnished with Hemofil® M Antihemophilic
(provider's name)

Factor (Human) Method M Monoclonal Purified (Hemofil® M AHF), Recombinate™ Antihemophilic Factor (Recombinant) (Recombinate™ rAHF), or FEIBA® VH Anti-Inhibitor Coagulant Complex Vapor Heated (FEIBA® VH) by Baxter Healthcare Corporation, free of charge for treatment of my eligible hemophilia patients.

- I certify that my patient being assisted through the Factor Plus℠ Program does not have and is not eligible for any public or private health insurance.
- I understand that acceptance into this program requires that my eligible patient complete and sign a Confidentiality and Release of Information Form to allow Baxter and the Factor Plus℠ Program administrator access to necessary medical and insurance records. I agree to explain to my patient the consent being requested and obtain the necessary medical and insurance documents.
- Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH has been prescribed for my patient in a medically appropriate manner based on current standards of medical care.
- I agree to allow Baxter and the Factor Plus℠ Program administrator to review the medical and insurance records for my Factor Plus℠ Program patient at any time for the purpose of verifying the patient's medical and insurance status.
- I understand that Baxter reserves the right to change or terminate this Program at any time, or to refuse to distribute Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH under this Program to any patient or provider.
- I agree to maintain a copy of this form and to furnish a copy to the Internal Revenue Service or other government agencies upon request.
- I certify that the Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH replaced by Baxter under this Program will be provided to my enrolled patient free of charge. No third party or patient will be charged for the free units and no free units will be distributed for sale to any individuals, or used by any other individuals.
- If I become aware of any changes in my eligible patient's circumstances that would affect his or her eligibility, I agree to notify immediately the Factor Plus℠ Program administrator.

____

Provider's Signature **Date**

____

Title

If you have any questions about the Factor Plus℠ Program, please call 800.548.4448 (Option 2)

Please see back of form for Enrollment and Eligibility Information

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Form B

FACTOR PLUS℠ Program

Patient Application

Patients (or parents or guardians of patients) must submit this form to enroll in the Factor Plus℠ Program.

Send completed forms to:

The Factor Plus℠ Program
c/o InTeleCenter™
P.O. Box 4280
Gaithersburg, MD 20885-4280
Fax Number: 240-632-3807

Date submitted: ____________________

A Provider Information – Dispensing Provider/Distributor

Provider name: ____________________

Provider phone number: ( ) ____________________

B Provider Information – Administering Provider

Patient's physician: ____________________

Physician's address: ____________________

Contact name at physician's office: ____________________

Phone number: ( ) __________ Fax number: ( ) __________

C Patient Information (Circle: New Enrollment Re-Enrollment)

Patient name: __________ Social Security number: __________

Date of birth: ____________________

Please attach proof of U.S. citizenship or permanent residence in the United States (i.e. birth certificate, passport, naturalization card).

D Clinical Information

Factor VIII deficiency **(check one):**

Mild (>5%) ______ Moderate (1-5%) ______ Severe (<1%) ______ Patient weight (kg): ______

Current Therapy **(check all that apply):**

On Demand ______ Inhibitor Patient ______ Preventive Therapy ______ Other: ______

I am currently using (check one):

[ ] Hemofil® M AHF
[ ] Recombinate™ rAHF
[ ] FEIBA® VH

If you have any questions about the Factor Plus℠ Program, please call 800.548.4448 (Option 2)

Please see back of form for Enrollment and Eligibility Information

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Form B

FACTOR PLUS℠ Program

Patient Application *(continued)*

Where are you generally purchasing and receiving Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH?

Dispensed

[ ] Home health care (independent)
[ ] Home health care (hospital-based)
[ ] Hospital pharmacy
[ ] Physician's office/clinic
[ ] Retail pharmacy
[ ] Treatment center
[ ] Other________________________

Administered

[ ] Hospital emergency room
[ ] Hospital inpatient
[ ] Physician's office/clinic
[ ] Self-administered at home
[ ] Treatment center
[ ] Other________________________

E Insurance Information – (Check appropriate boxes)

❑ **Factor Assist™ Program:** I am not presently enrolled in Baxter's Factor Assist™ Program or any other Baxter program that would allow me access to product.

❑ **Pending Insurance:** Please provide information regarding whether you are pending insurance and expect to obtain it in the future. If so, what type.________________________

❑ **Pre-existing Condition:** Patient's insurance has pre-existing condition clause of _____ months. Patient will be eligible for ________________________
Insurer Name

on ________________________
(Date)

❑ **Lapse of Insurance:** Please explain why you are currently experiencing a lapse in insurance coverage: ________________________

❑ **Exceeded Benefits:** Patient has exceeded insurance benefits.

❑ **No Insurance:** If you have no insurance, please certify to the following statement and include copies of any correspondence demonstrating lack of current health insurance coverage.

I certify that I do not have and am not eligible for any public or private health insurance. I also certify that I do not have the financial resources to pay for the product.

____

Patient's (or Parent's or Guardian's) Signature **Date**

Note: Patients receiving any type of medical insurance for their hemophilia are considered insured for the purposes of the Factor Plus℠ Program, even if the policy has limited or no prescription drug coverage.

If not the sole financial supporter for the patient, please give names of other supporters:

____

____

Form B

FACTOR PLUS^{SM} Program

Patient Application *(continued)*
Applicant Certification
Confidentiality and Release of Information

Patients must complete and sign this form to be considered for the Factor Plus^{SM} Program. If the patient is a minor, this page must be completed by the primary wage earner.

Patient Eligibility Information

Patient Name: ______________________ Patient Social Security Number: ______________

Spouse Name: ______________________ Spouse Social Security Number: ______________

Parent/Guardian Name: ________________ Parent/Guardian Social Security Number: ______________

Patient Address: ____________________________ Phone Number: (   ) __________

____

Family Household Income (Gross Annual): $ ____________

Number of Family Members ________ Out of Pocket Medical Expenses (Annual) $ ____________

Occupation: ________________ Employer: ____________________

Employer Address: ____________________ Employer Phone Number: (   ) __________

____

Spouse Occupation: ________________ Spouse Employer: ____________________

Employer Address: ____________________ Employer Phone Number: (   ) __________

____

College or University (if applicable): ______________________________

Spouse College or University (if applicable): ______________________________

I understand that Baxter and the Factor Plus^{SM} Program administrators have the right to request documentation of our family income from income tax forms or information on our family assets.

CONFIDENTIALITY WAIVER

I would like to receive Hemofil® M AHF [   ], Recombinate™ rAHF [   ], or FEIBA® VH [   ], free of charge, through the Factor Plus^{SM} Program offered by Baxter Healthcare Corporation. I verify that the information provided in this application is complete and accurate to the best of my knowledge. I understand that at such time as I obtain prescription coverage or have the financial resources to pay for the cost of Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH, I will notify the Factor Plus^{SM} Program of such a change in my coverage status. I understand that, by my signature, any and all information that I provide may be shared with my treating physician. In order to participate, I hereby certify that I do not have, nor am I eligible for, any private or public insurance for my hemophilia care. I have made diligent attempts to obtain insurance (both private and public) and have been unable to obtain any insurance.

I have read, understand, and agree to the confidentiality waiver.

____ ______________

Patient's (or Parent's/Guardian's) Signature **Date**

If you have any questions about the Factor Plus^{SM} Program, please call 800.548.4448 (Option 2)

Please see back of form for Enrollment and Eligibility Information

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Form B

FACTOR PLUS℠ Program

Patient Application *(continued)*

Release of Medical Information

I understand that in order to determine my eligibility to participate in the Factor Plus℠ Program, Baxter needs information about my medical condition, and also about any health insurance that might help pay for Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH. By my signature, I agree that Baxter's Factor Plus℠ Program and/or the Factor Plus℠ Program administrator may contact my health care provider to request information concerning my medical condition, and I hereby direct them to provide information relative to my medical condition and treatment of drug therapy as requested. In addition, I agree that the Factor Plus℠ Program and/or the Factor Plus℠ Program administrator may contact my insurer to obtain benefits information for Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH.

The Baxter Factor Plus℠ Program and/or its Factor Plus℠ Program administrator agree not to disclose any information obtained from these sources to any third party except as required by applicable law.

I also understand that Baxter may discontinue or modify the Factor Plus℠ Program at any time, and that although Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH may be given to me without cost now, it does not mean that I will be entitled to receive it without cost indefinitely. Further, I agree that this product is only for my use, it will not be sold or given for use to any other person, and no third party will be billed for this product.

I have read, understand, and agree to the release of medical information statement.

Patient's (or Parent's/Guardian's) Signature **Date**

If you have any questions about the Factor Plus℠ Program, please call 800.548.4448 (Option 2)

Please see back of form for Enrollment and Eligibility Information

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Form C

FACTOR PLUS^{SM} Program

Physician Certification and Consent

A physician must submit this form before a patient may enroll in the Factor Plus^{SM} Program.

Send completed form to: The Factor Plus^{SM} Program
c/o InTeleCenter™
P.O. Box 4280
Gaithersburg, MD 20885-4280
Fax Number: 240-632-3807

Date submitted: ______________________

- I have verified that ______________________ [patient name] does not have and is not eligible for any public or private health insurance.
- I understand that acceptance into this program requires that my patient completes and signs a Confidentiality and Release of Information Form to allow Baxter access to necessary medical and insurance records. I agree to explain to my patient the consent being requested and help obtain the necessary medical and insurance documents.
- ❑ Hemofil® M AHF, ❑ Recombinate™ rAHF, or ❑ FEIBA® VH has been prescribed for this patient in a medically appropriate manner based on current standards of medical care.
- Total units used in previous 12 months______________________.
- Estimated units needed in next 12 months______________________. If you anticipate that the patient's usage in the next 12 months will exceed the usage in the previous 12 months, then please attach a statement explaining the reason.
- I agree to allow the authorized Factor Plus^{SM} Program administrator to review the medical and insurance records for my Factor Plus^{SM} Program patient at any time for the purpose of verifying the patient's medical and insurance status.
- I understand that Baxter reserves the right to change or terminate this Program at any time, or to refuse to distribute Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH under this Program to any patient or provider.
- I agree to maintain a copy of this form and to furnish a copy to the Internal Revenue Service or other government agencies upon request.
- I certify that the Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH replaced by Baxter under this Program will be provided to my enrolled patient free of charge. No third party or patient will be charged for the free units and no free units will be distributed for sale to any individuals, or used by any other individuals.
- If I become aware of any changes in my eligible patient's circumstances that would affect his/her eligibility, I agree to notify immediately the Factor Plus^{SM} Program administrator.

The physician must sign the following statement:

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the authorized Factor Plus^{SM} administrator of any changes I become aware of that would affect the eligibility status of the patient.

______________________ ______________________
Physician Signature Date

______________________ ______________________
Address Phone Number

____
Contact Name

____
Approved Dispensing Provider/Distributor

____
Name

____
Address

____
Phone Number

Form D

FACTOR PLUS℠ Program

Product Replacement Request

To receive replacement product, providers may submit this form throughout the month, but no later than the 20th of the following month. Complete one form for each patient enrolled in the Factor Plus℠ Program. This form, along with a copy of all original prescriptions, must be submitted before any product is shipped.

Date submitted: ____________________

A Provider Information

Baxter customer number: A ____________________

Provider name: ____________________

Contact person: ____________________

B Patient Information – (Circle: New Enrollment Re-Enrollment)

Patient name: ____________________

Social Security number: ____________________ Patient weight (kg): ____________

Patient dose (units/month): ____________________

C Clinical Information

Factor VIII deficiency **(check one):**
Mild (>5%) _____ Moderate (1-5%) _____ Severe (<1%) _____ Patient weight (kg): _____

Current Therapy **(check all that apply):**
On Demand _____ Inhibitor Patient _____ Preventive Therapy _____ Other: _____

Insurance Status

Please indicate the current status of obtaining insurance coverage or public funding for Factor product for this patient:

____

____

____

If you have any questions about the Factor Plus℠ Program, please call 800.548.4448 (Option 2)

Please see back of form for Enrollment and Eligibility Information

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Form D

FACTOR PLUS℠ Program

Product Replacement Request *(continued)*

Antihemophilic Factor Units Dispensed (check one):

[ ] Hemofil® M Antihemophilic Factor (Human) Method M Monoclonal Purified (Hemofil® M AHF)
[ ] Recombinate™ Antihemophilic Factor (Recombinant) (Recombinate™ rAHF)
[ ] FEIBA® VH Anti-Inhibitor Coagulant Complex Vapor Heated (FEIBA® VH)

Date Dispensed	Lot No.	Potency	No. of Vials Per Month	Total No. of Units
Example: 12/01/91	1234A123	550	2	1,100

If you have any questions about the Factor Plus℠ Program, please call 800.548.4448 (Option 2)
Please see back of form for Enrollment and Eligibility Information

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Form D

FACTOR PLUS℠ Program

Product Replacement Request *(continued)*

CERTIFICATION STATEMENT

I certify that the product reported in this form, for which I am requesting free replacement, was purchased by me or my institution. Further, I certify that the product replaced by Baxter Healthcare Corporation under this Program will be given to the patient indicated, free of charge. No third party or patient will be charged for the free units, and no free units will be distributed for sale to any individuals. In addition, I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the Factor Plus℠ Program administrator of any changes I become aware of that would affect the eligibility status of the patient. I also understand that replacement product may not be the identical potencies originally distributed to the patient and that, further, Baxter will make every effort to replicate or replace the exact number of units documented on this form to the nearest clinical requirement. Finally, I certify that the patient receiving this free replacement product from Baxter has attempted to obtain insurance coverage for Hemofil® M AHF, Recombinate™ rAHF, or FEIBA® VH but that at this time the patient does not have and is not eligible for any public or private health insurance.

Provider's Signature: ______________________________ **Date:** ____________________

Title: ______________________________ **Phone number:** ( ) ____________________

Physician name: ____

Physician address: ____

____

____

____

If you have any questions about the Factor Plus℠ Program, please call 800.548.4448 (Option 2)
Please see back of form for Enrollment and Eligibility Information

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