Betaseron Patient Assistance Program
Patient Enrollment Application – Patient Information

Please complete each section to the fullest extent possible and return this confidential enrollment application to the Betaseron Patient Assistance Program. If an item does not apply, please note "N/A" on that line. If you have any questions about the application, please call the Betaseron Patient Assistance Program at 1-877-836-5724.

Section 1 – Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Alternate Phone: _____

OK to leave message? ❑ Yes ❑ No OK to leave message? ❑ Yes ❑ No

Date of Birth: _____ Gender: _____ Social Security #: _____

Section 2 – Insurance Information

❑ I have no insurance coverage, including Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance (Skip to Section 3).

Primary Insurance Information (including Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance)

Payer Name: _____ Payer Phone #: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Does this plan cover prescription drugs? ❑Yes ❑ No

Secondary Insurance Information (including Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance)

Payer Name: _____ Payer Phone #: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Does this plan cover prescription drugs? ❑Yes ❑ No

Section 3 – Public Programs

Have you applied for Medicare, Medicaid, VA, Department of Defense or other similar governmental assistance?

❑ Yes Program Name: _____

Date Applied: _____

Status of Application: ❑ Approved ❑ Pending ❑ Denied

If denied, please enclose copy of denial

❑ No Do you intend to apply? ❑ Yes ❑ No

If not, why? _____

Section 4 – Financial and Other Information

Annual Household Income: _____ # of household members dependent on income: _____

Annual household out-of-pocket medical expenses not reimbursed by insurance (please EXCLUDE costs for Betaseron):

Hospital $ _____ Doctor $ _____ Drugs $ _____

Other $ _____ Portion of health insurance premium you pay $ _____

Section 5 – Required Documentation

Please submit a copy of the following with your application:

1. Income verification for all sources of household income, including:
   - Copy of your most recent federal tax return
   - Statement of Social Security benefits
   - Statement of pension benefits
   - Statement of disability benefits
   - Statement of alimony and/or child support received
   - Unemployment benefits

2. Copy of your insurance card(s) and insurance denial for Betaseron, if applicable. Please provide copies of both the front and back of your insurance cards.

Section 6 – Patient Declaration

I verify that the information provided in this application form is current, complete, and accurate, and understand that it will be reviewed and relied upon to determine my eligibility for free product under the Betaseron Patient Assistance Program ("the Program"). I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the Program. The Program also reserves the right to make an independent determination of financial and medical need. I also understand that Bayer HealthCare Pharmaceuticals Inc. reserves the right at any time, and without notice, to modify or discontinue this program with respect to any patient, or in its entirety. I authorize the Program to use and obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application to administer the Program. I understand that the Program will use and give out my information to help me with my reimbursement questions, to see if I qualify for free product through patient assistance, or to refer me to, or determine my eligibility for, other programs, foundations, or alternate sources of funding or coverage to help me with the costs of obtaining Betaseron. I acknowledge that I am a legal resident of the United States. I authorize my health care providers, health plans, and health insurers to use and disclose to Bayer and the Program and their authorized agents and assignees, all medical records and financial information with respect to my treatment and my eligibility for treatment. I understand that I may not, and agree that I will not, seek reimbursement from any private insurance or public assistance program for any Betaseron made available to me under the Program.

_____

Patient Signature Date

Please return this completed form to:
Betaseron Patient Assistance Program
PO Box 221349
Charlotte, NC 28222-1349
Toll free fax 1-877-744-5615

Betaseron Patient Assistance Program
Patient Enrollment Application – Physician Information

Please complete each section to the fullest extent possible and return this confidential enrollment application to the Betaseron Patient Assistance Program. If an item does not apply, please note "N/A" on that line. If you have any questions about the application, please call the Betaseron Patient Assistance Program at 1-877-836-5724.

Patient Name: _____ Social Security #: _____

Section 1 – Primary Physician Information

Physician Name: _____

Site/Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Physician Specialty: _____ Office Contact Name: _____

Telephone #: _____ Fax #: _____

DEA #: _____ Tax ID #: _____

Section 2 – Prescription

Rx: Betaseron® (Interferon Beta 1-b) SC Injection 0.25mg (1cc)

Established Betaseron Patient, check here:

- ❑ Dispense initial shipment up to 90 day supply

  Sig: Betaseron® (Interferon Beta 1-b) SC Injection (0.3mg) QOD
  PRN refill shipments up to one year (90 day supplies)

New Betaseron Patient, check here:

- ❑ Dispense initial shipment up to 90 day supply

  Sig: Titration Per Package Insert:
  Weeks 1 – 2: 0.0625 mg/0.25 cc QOD SC
  Weeks 3 – 4: 0.1250 mg/0.50 cc QOD SC
  Weeks 5 – 6: 0.1875 mg/0.75 cc QOD SC
  Weeks 7 +: 0.2500 mg/1.00 cc QOD SC
  PRN refill shipments up to one year (90 day supplies)

  Other (please specify) _____

Section 3 – Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Betaseron based on my professional judgment of medical necessity. I certify that the patient is being treated in an outpatient setting and that, to the best of my knowledge, the patient does not have any other insurance coverage for Betaseron. I authorize Bayer HealthCare Pharmaceuticals Inc., its affiliated companies or subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

I appoint the Betaseron Patient Assistance program solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

_____

Physician Signature Date

Please return this completed form to:
Betaseron Patient Assistance Program
PO Box 221349
Charlotte, NC 28222-1349
Toll free fax 1-877-744-5615