Nexavar REACH Program

PO Box 220765
Charlotte, NC 28222-0765
Phone: **1.87.REACH.4.IT (1.877.322.4448)**
Fax: **1.866.639.5181**

Enrollment Form

Please complete each section to the fullest extent possible and return this confidential enrollment form to REACH. If an item does not apply, please note "N/A" on that line.

Physician Information

Physician Name: ____________________
Site/Facility Name: ____________________
Street Address: ____________________
City: ____________ State: ______ ZIP: ________
Office Contact: ____________ Telephone: ____________
Fax: ____________ Best Time to Call: ____________
Office Contact E-Mail: ____________________
State License #: ____________________
Tax ID #: ____________ **NPI #:** ____________

In Office Physician Dispensing Information*

(*Complete this section only if the physician is dispensing in the office)

Payer Specific Provider # (Primary Insurance): ____________
Payer Specific Provider # (Secondary Insurance): ____________
Tax ID #: ____________________

Patient Diagnosis Information

Patient Diagnosis/ICD-9 Code: ____________________

Prescription

❑ Benefit verification only

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Nexavar REACH Program), medication will be shipped via a specialty pharmacy provider to the patient's home address (listed above right) unless otherwise indicated by practitioner:

____

Patient Name: ____________________
Product Name: NEXAVAR 200 mg tablets
Supplied as: 120 tablets per bottle (30-day supply)
(Recommended dosage: 400 mg po bid)
Dosage: ____________ Sig: ____________
Quantity: ____________________
Refill(s): ________ DEA #: ____________ Date: ____________

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 NEXAVAR based on my professional judgment of medical necessity. I authorize Bayer and Onyx, its affiliated companies or subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

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

I authorize the Nexavar REACH program to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the Nexavar REACH program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance verification assessment.

Physician Signature: ____________________
Date: ____________________

Patient Information

Patient Name: ____________________
Street Address: ____________________
City: ____________ State: ______ ZIP: ________
Date of Birth: ____________ SSN: ____________
Daytime Telephone: ____________________
Evening Telephone: ____________ Best Time to Call: ________
Cell Phone: ____________________
Email: ____________________
Alternative Contact Name: ____________________
Alternative Contact Telephone: ____________________
Patient Primary Language: ____________________

Patient Insurance Information

Primary Insurer: ____________________
Telephone: ____________________
Policy ID Number: ____________ Group Number: ____________
Subscriber Name/Date of Birth: ____________________
Does this plan cover prescription drugs? ❑ YES ❑ NO

Secondary Insurer: ____________________
Telephone: ____________________
Policy ID Number: ____________ Group Number: ____________
Subscriber Name/Date of Birth: ____________________
Does this plan cover prescription drugs? ❑ YES ❑ NO

Patient Financial Information*

Current annual household income: $ ____________
Number of household members dependent on income stated above (include applicant): ____________
Source of income: ❑ Job ❑ Family ❑ Public Assistance ❑ SSI/SSDI
❑ Other (Please explain): ____________________

***Income documentation will be required in order to assess Patient Assistance Program eligibility.** (ie, 1040 tax return, SSA-1099, W-2 Form, etc.)

Patient Authorization

I verify that the information provided in this enrollment form is current, complete, and accurate. I further understand that the Nexavar REACH Program may request documentation from me, my employer, my health care provider or my insurance company to verify my financial or insurance information. I understand that any patient assistance provided to me by Bayer and Onyx through the Nexavar REACH Program is contingent upon my ability to meet the eligibility criteria for the program and that the Nexavar REACH Program reserves the right to make an independent determination of my financial and medical need. I also understand Bayer and Onyx reserve the right at any time, and without notice, to modify or discontinue the Nexavar REACH Program and any assistance provided with respect to any patient (including me), or to modify or discontinue the program entirely. I authorize the Nexavar REACH Program to use and obtain medical, financial or provider information from my prescribing physician, insurance company, specialty pharmacy and other sources as deemed necessary to ensure the accuracy and completeness of this enrollment form, to provide services to me, and to otherwise administer the Nexavar REACH Program. I understand that the Nexavar REACH Program will use and give out my information to help me with my reimbursement questions, to see if I qualify for patient assistance, or to refer me to, or to determine my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the costs of obtaining my Nexavar treatment. I understand that information I provide may be subject to re-disclosure, in which case it may no longer be protected under federal privacy rules. I acknowledge that I am a legal resident of the United States. I authorize my health care providers, insurance companies, and specialty pharmacies to use and disclose to Bayer, Onyx, the Nexavar REACH Program and their authorized agents and assignees, all medical records and financial information with respect to my treatment, my eligibility for assistance, the coordination of my treatment of Nexavar (and the receipt of my medication), and my participation in the Nexavar REACH Program for the purposes of providing services to me and otherwise administering the program. I understand that my health care providers and insurance company will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be eligible to receive assistance through the Nexavar REACH Program. This authorization will terminate one year from the signature date below, unless revoked by my written notice. I understand that my revocation will not affect any action taken before it is received by the REACH program. I am entitled to a copy of this authorization.

Patient/Legal Guardian or Representative* Signature: ____________________
*a description of such guardian's or representative's authority to act for the patient must be provided.

Date: ____________________

In addition to using my information for the Nexavar REACH Program, I authorize Bayer, Onyx and the Nexavar REACH Program to use and give out my information to send me information or materials related to Nexavar (or any other related products or services which I might be interested), to contact me occasionally to get my feedback (for market research purposes) about Nexavar or the Nexavar REACH Program, to operate (and improve the quality of) the Nexavar REACH Program, or otherwise as required or permitted by law. If you do not wish [to receive information related to Nexavar (or any related products or services) or] to be contacted occasionally for market research purposes, you may call the Nexavar REACH Program's toll-free number 1-866-NEXAVAR (1-866-639-2827) at any time.

❑ I DO NOT wish to receive additional information related to Nexavar.