REACH℠ (Resources for Expert Assistance and Care Helpline)

Phone: (877) 322-4448 Fax: (800) 513-1824
PO Box 221289 Charlotte, NC 28222-9910

REQUEST TYPE (PLEASE CHOOSE ONE)

☐ **Benefit Verification Request**
Please complete sections 1-3 and 5

☐ **Patient Assistance Program**
Please complete sections 1-5

SECTION 1 – PHYSICIAN PORTION

Physician Name ____________________________ State License # __________ DEA#________________

Name of Group/Hospital _______________________________ _______Tax ID # ____________________

Correspondence Address ____

City ______________________________________ ____State ____________ ___Zip Code ____________

Telephone ____________________________ ___Fax ____

Office Contact Name and Extension____

Ship Address (if different than above) ____

City ____ State ___________ Zip Code _____________

Bayer Product (indicate drug and number of vials requested--# of vials only needed for PAP):

☐ Campath (alemtuzumab)
# of 30mg vials __________

☐ Fludara (fludarabine)
# of 50mg vials _________

☐ Leukine (sargamostim)
# of 250mcg vials __________
# of 500mcg vials __________

Dose __________________________________ Route of Administration____________________________

Dosing Regimen _________________________ Site of Service __________________________________

Treatment Starting Date ___________________ Planned Treatment Completion Date _________________

Patient's Diagnosis (including ICD-9 code) ____

Physician certification: I agree to follow this patient through his/her entire course of Campath/ Fludara/ Leukine therapy. I understand that I will be sent PAP vials once I have provided all requested documentation in a timely manner to Bayer or its agents regarding therapy with Bayer products for this patient. I understand that, due to clinical uncertainty, the REACH program does not provide reimbursement or PAP services for the use of Leukine for Crohn's Disease or Campath for Multiple Sclerosis at this time and certify that the requested drug is not intended for these indications.

Physician Signature ____________________________________ Date ______________________________

SECTION 2 – PATIENT PORTION

Patient Name: ____Telephone: _______________________

Correspondence Address:____

City: ___________________________________ State: _________________Zip Code: _______________

Social Security #: _______________________________________ Date of Birth: _______________________

SECTION 3 – HEALTH INSURANCE INFORMATION

Do you have any type of health insurance, including public programs such as Medicare, Medicaid, or any other assistance programs?

☐ Yes ☐ No (If yes, complete the table below, including all primary and secondary insurance policies.)

	Medicare	Medicaid	Commercial	Other
Insurance Company Name				
Policy Number				
Group Number				
Telephone Number				
Policy Holder's Name				
Policy Holder's Date of Birth				

Has coverage for therapy been specifically denied? ☐ Yes ☐ No

If yes, please state the reason ____

SECTION 4 – FINANCIAL/OTHER INFORMATION (TO BE COMPLETED ONLY IF PATIENT HAS NO INSURANCE)

Financial Information*

Current Annual household gross income $__________________

Number of household members dependent on income stated above (include applicant) _____________

Out-of-Pocket Medical Expenses $___________________

***Income documentation is required in order to assess Patient Assistance Program eligibility. Please submit the most recent income documentation (i.e., 1040 tax return, SSA-1099, W-2, pay stub, etc.).**

Other Information

Are you a veteran of the U.S. Armed Forces? ☐ Yes ☐ No

Do you reside in the U.S. or U.S. territory and meet residency criteria for some form of potential public assistance? ☐ Yes ☐ No

Medicaid

Have you ever applied to Medicaid? ☐ Yes ☐ No

If No, please explain why you have not applied. ____

If Yes, and your application was rejected, explain reason for rejection. ______________________________

SECTION 5 – PATIENT CONSENT AND AUTHORIZATION

I certify that all of the above statements and any information provided are correct and that I understand eligibility under this program is subject to Bayer's approval. I grant Bayer or its agents the right, at all times, to investigate any and all claims made under this program. I agree that Bayer HealthCare Pharmaceuticals, or its representatives, and/or any organization selected by Bayer HealthCare Pharmaceuticals to represent it, may see, or get a copy of, all medical, prescribed drug, and insurance coverage records from my healthcare provider or my insurance company which pertain to treatment with Bayer's product for:

____

Print Patient's Name

This information is for the sole use of Bayer HealthCare Pharmaceuticals and/or its representatives. Unless required law, information will not be given in an identifiable form to any other persons unless the patient agrees to its release in writing. This authorization will become effective when signed below and will remain in effect until revoked by the patient. A photocopy of this form is as valid as the original.

____

Signature of Patient or Legal Representative Date

NOTE: Bayer reserves the right to limit or modify in whole or in part the Patient Assistance Program, specific to any patient or provider, or terminate the program, at any time without further notification. In addition, no patient will be accepted into the program without the provider's or patient's (or legal representative's) original signature on this form. Bayer reserves the right to make a separate, independent determination of patient eligibility.