The Betaseron Foundation
Patient Enrollment Application Physician Information

To be eligible for assistance, a patient must have a confirmed diagnosis of MS. The information requested below is necessary to complete the patient's application. The physician and the patient will be notified of the application determination. If you have any questions about the application or application process, please call The Betaseron Foundation at 1-800-948-5777.

Patient Name:

Patient's Social Security Number:

Section 1 - Primary Physician Information (Physician, regardless of specialty, who is responsible for ongoing patient care)

Physician Name:

Street Address:

City: State: Zip:

Telephone: Fax Number:

DEA Number: Specialty:

Office Contact Name:

Section 2 - Medical Necessity Information

Does patient have a confirmed diagnosis of MS? ☐ Yes ☐ No

(If no, please indicate patient's diagnosis.)

Is patient currently taking Betaseron® (Interferon beta-1b) for SC injection? ☐ Yes ☐ No

Do you plan to prescribe Betaseron therapy if product is available to patient? ☐ Yes ☐ No

I certify that Betaseron therapy is medically indicated for this patient. I verify that the information provided is complete and accurate to the best of my knowledge.

Physician Signature **Date**

Please return this completed form to:
The Betaseron Foundation
PO Box 221349
Charlotte, NC 28222-1349
Toll Free Fax 1-877-744-5615

The Betaseron Foundation
Patient Enrollment Application Patient Information

Please complete each section to the fullest extent possible. If an item does not apply to your situation, please note "N/A" on that line. If you have any questions about the application or application process, please call The Betaseron Foundation at 1-800-948-5777.

Section 1 - Patient Information

Patient Name:

Contact:

Street Address:

City: State: Zip:

Home Telephone: Work Telephone:

Social Security Number: Date of Birth:

How did you first hear about The Betaseron Foundation?

Section 2 - Health Insurance Information

☐ I have no insurance coverage, including Medicaid or Medicare. (Skip to Section 3 - Public Programs)

Primary Insurance Carrier

Insurance Company or Medicare/Medicaid Claims Payer:

Telephone: Contact Name, If Any:

Policy ID Number (Including Any Letters): Group Number:

Subscriber Name: Subscriber's Date of Birth:

Subscriber's Relation to Patient: Employer/Group Name:

Does this policy cover outpatient prescription drugs? ☐ Yes ☐ No

If covered, what are your insurance cost share requirements (deductibles & copays) for outpatient prescription drugs?

Deductible $_____ Copay $_____ or _____%

Secondary Insurance Carrier

Insurance Company or Medicare/Medicaid Claims Payer:

Telephone: Contact Name, If Any:

Policy ID Number (Including Any Letters): Group Number:

Subscriber Name: Subscriber's Date of Birth:

Subscriber's Relation to Patient: Employer/Group Name:

Does this policy cover outpatient prescription drugs? ☐ Yes ☐ No

If covered, what are your insurance cost share requirements (deductibles & copays) for outpatient prescription drugs?

Deductible $_____ Copay $_____ or _____%

Section 3 - Public Programs

Has patient or guardian applied for financial assistance through Medicaid or other public assistance programs?

☐ Yes: Date of Application: Program Applied to:

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

(Family is defined as all individuals in a single household who contribute to each other's maintenance and support.)
Size of Family: Number of Dependent Children:

Annual family gross income last calendar year?

Has your annual income changed significantly? ☐ Yes ☐ No
If yes, please explain.

Annual family out-of-pocket medical expenses not reimbursed by insurance for all illnesses [please EXCLUDE costs for Betaseron® (Interferon beta-1b) for SC injection].
Hospital($) Doctor($) Drugs($) Other($)

Portion of Health Insurance Premium Cost you must pay($)

Section 5 – Required Documentation

Please submit a copy of the following information with your application.

1. Income verification for all sources of household income. This may include:
   - Copy of your most recent federal tax return (if you or other members of your household are required to file)
   - Statement of Social Security benefits (copy of award letter, check or recent bank statement indicating monthly benefit amount)
   - Statement of pension benefits
   - Statement of short and/or long term disability benefits
   - Statement of alimony and/or child support received
   - Unemployment benefits
2. A 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 card(s).

Section 6 - Applicant Declaration

I verify that the information provided in this application is complete and accurate. I further understand that reported financial information may be verified by an audit as deemed necessary by the Foundation. I understand that assistance will terminate if the Foundation becomes aware of any fraudulent activity relating to this application or the assistance provided by the Foundation to me or if Betaseron (Interferon beta-1b) is no longer prescribed for me. I understand that the Foundation reserves the right at any time, or for any reason, and without notice to (i) modify the Application Form, (ii) modify or discontinue any or all of the programs and the related eligibility criteria, or (iii) terminate assistance.

I authorize the Foundation and its agents to obtain information on my Betaseron dosing information from the prescribing physician, insurance coverage information from my employer or insurance company(ies) and other information related to the treatment of multiple sclerosis as necessary to complete the application process or verify the accuracy of any information provided with this application. I further authorize the Foundation and its agents to provide Berlex Laboratories, Inc. with information concerning any assistance provided to me by the Foundation.

Patient Signature **Date**

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The Betaseron Foundation
Authorization to Release Medical Information and Assignment of Benefits

Patient Name: _____

In order for me to receive Betaseron from The Betaseron Foundation, I authorize my health care provider(s) and my insurance company(ies) to disclose to The Betaseron Foundation and its employees, third party administrators, agents and other representatives (collectively "the Foundation"), information about me, my current medical condition and my health insurance coverage.

I understand that it will not be necessary for me to file any claims for Betaseron provided by the Foundation. I authorize payment of medical benefits for Betaseron provided through the Foundation to be made directly to the Foundation. This authorization shall extend to all claims submitted on my behalf by the Foundation. By signing this authorization, I agree to immediately provide the Foundation (at the address listed below) with any payments or proceeds that I might receive from my insurance company(ies) for Betaseron provided to me by the Foundation. I understand that any failure to do so will result in immediate termination of my relationship with the Foundation (including any additional receipt of Betaseron from the Foundation).

I understand that my health care provider(s) and insurance company(ies) 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 able to receive Betaseron from the Foundation. I may revoke this authorization by mailing or faxing a signed letter of revocation to the Foundation at the address listed below, but if I revoke this authorization, I will no longer be able to receive Betaseron from the Foundation. I am entitled to a copy of this authorization.

This authorization expires one year from the date I execute this Authorization or one year after the date I am no longer treated with Betaseron, whichever is later.

Patient Signature _____ **Date** _____

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