BERLEX making medicine work **Berlex Oncology CamCare™** PO Box 221289 Charlotte, NC 28222-1289 (800) 473-5832 (800) 513-1824 FAX	**FAX COVER SHEET** **Leukine Reimbursement Support™** PO Box 221289 Charlotte, NC 28222-1289 (800) 321-4669 (800) 513-1824 FAX
To: Mike	Date/Time: 02/21/2006 4:45:18 PM
From: Ernestine Tomlin	Fax number: 1 (908) 713-7729
Subject: Application	Pages: 2

The following services are also available through the CamCare™ and Leukine Reimbursement Support Lines:

- Alternate Coverage Research
- Benefit Verifications
- Coding Assistance
- Claims Appeal/Denial Assistance
- Claims Tracking
- Prior Authorization Assistance
- Patient Assistance

Reimbursement Services are available 9am – 5pm ET Monday through Friday.

Berlex Oncology CamCare™ Application Form

Phone: (800) 473-5832 Fax: (800) 513-1824
PO Box 221289 Charlotte, NC 28222-9910

PROGRAM TYPE (PLEASE CHOOSE ONE)

❑ **Drug Replacement Program** — 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: _____
Telephone: _____ Fax: _____
Office Contact Name and Extension: _____
Ship Address (if different than above): _____
City: _____ State: _____ Zip: _____

Berlex Product (indicate drug and number of vials requested):

☐ Campath (alemtuzmab) 30 mg
# of vials: _____

☐ Fludara (fludarabine phosphate) 50 mg
# of vials:_____

☐ Leukine (Sargramostim)
_____Lyophilized 250mcg (# of vials)
_____Liquid 500mcg (# of vials)

Dose: _____ Route of Administration: _____
Dosing Regimen: _____ Site of Service: _____
Treatment Start Date:_____ Treatment Completion Date: _____
Patient's Diagnosis: _____

Physician Certification: I understand that I agree to follow this patient through his/her entire course of (merge field with product name). I understand that I will be sent vials once I have provided all requested documentation in a timely manner to Berlex or its agents regarding therapy with Berlex products for this patient.

Physician Signature: _____ Date: _____

SECTION 2 - PATIENT PORTION

Patient Name: _____ Telephone: _____
Correspondence Address: _____
City: _____ State: _____ Zip: _____
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: $_____

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 the above statements and any information provided are correct and that I understand eligibility under this program are subject to Berlex's approval. I grant Berlex or its agents the right, at all times, to investigate any and all claims made under this program. I agree that Berlex Corporation, or its representatives, and/or any organization selected by Berlex Corporation 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 Berlex's product for:

_____

Print patient's name

This information is for the sole use of Berlex Corporation and/or its representatives. Unless required by 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 in writing by the patient. A photocopy of this form is as valid as the original.

_____

Signature of Patient or Legal Representative Date

NOTE: Berlex 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 and patient's (or legal representative's) original signature on this form. Berlex reserves the right to make a separate, independent determination of patient eligibility.