Zevalin® (Ibritumomab Tiuxetan) Support Services Application

RESULTS™
Reimbursement Support Line-Trained Specialists

Phone: **866-298-8433** Fax: **800-513-8095**

PATIENT INFORMATION

Name _____ SS # _____ Gender ☐ F ☐ M

Address _____ **Primary Diagnosis** ***ICD-9*** ____ ____ ____ ____ ____

City State Zip _____ Other Previous Treatments _____

Home Phone _____ Previous Zevalin treatment? ☐ Y ☐ N

Date of Birth _____ Zevalin Treatment Dates: In-111 ____/____/____ Y-90 ____/____/____ ☐ TBD

PATIENT INSURANCE INFORMATION ☐ Check if no insurance Please attach copies of both sides of all patient's insurance cards.

Primary Insurance _____ Policy # _____ Group # _____ Phone # _____

Secondary Insurance _____ Policy # _____ Group # _____ Phone # _____

Policy Holder Information (if different than patient): Name _____ Relation to Patient _____

REFERRING PHYSICIAN

Name _____ Address _____ Tax ID # _____

Facility _____ City State Zip _____ NPI # _____

Office Contact _____ Phone _____ Fax _____

PHYSICIAN ADMINISTERING In-111 ZEVALIN

Name _____ Address _____ Tax ID # _____

Facility _____ City State Zip _____ NPI # _____

Office Contact _____ Phone _____ Fax _____

PHYSICIAN ADMINISTERING Y-90 ZEVALIN ☐ Check if same as administering In-111 Zevalin

Name _____ Address _____ Tax ID # _____

Facility _____ City State Zip _____ NPI # _____

Office Contact _____ Phone _____ Fax _____

RADIOPHARMACY

Facility _____ Phone _____ Fax _____

Address _____ City State Zip _____

PATIENT AUTHORIZATION

- I would like to enroll in Zevalin Support Services sponsored by Cell Therapeutics, Inc. (CTI).
- I authorize the physician(s) listed above, the Zevalin therapy site, and the health insurer(s) listed above to disclose to CTI and its representatives, health information relating to my diagnosis listed above, including treatment and health insurance policy information necessary to ascertain any insurance benefit that may be available for Zevalin, to coordinate delivery of Zevalin, and to provide me with educational materials and support services.
- Once my health information has been disclosed to CTI, I understand that federal privacy laws may no longer protect the information, however, CTI and its representatives agree to protect the disclosed health information by using and disclosing it only for the purposes authorized by this form. This limitation continues even in the event of expiration or revocation of my Authorization.
- I understand that I may refuse to sign this Authorization and that my refusal is not communicated to my healthcare provider(s) or my health insurer(s).
- I may cancel this Authorization at any time by mailing a letter requesting such cancellation to: Zevalin Support Services, 501 Elliott Avenue West #400, Seattle WA 98119.
- Canceling this Authorization will end further disclosure of my Health Information by CTI and its representatives as well as the delivery of services related to the Zevalin Support Services program. I understand that health information already used or disclosed in reliance of this Authorization may not be protected from disclosure.

  This Authorization expires five (5) years from the date this Authorization is signed.

Patient Signature _____ Date _____

PHYSICIAN AUTHORIZATION

I authorize CTI and its representatives to use the information disclosed in this form for the sole purpose of enrolling the above named patient in CTI's Zevalin Support Services, under which reimbursement services and the delivery of Zevalin will be coordinated on behalf of the above named patient.

Physician Signature _____ Date _____