

foregoing, and will make every effort to correct those errors.

Please provide a copy of this application to your patient for their records.

## Celgene Patient Support® Enrollment Form

Phone: 1-800-931-8691 Web site: www.celgenepatientsupport.com Fax: 1-800-822-2496 E-mail: patientsupport@celgene.com

Online enrollment also available at www.celgenepatientsupport.com

PLEASE CHECK ALL SERVICES FOR WHICH YOU ARE APPLYING **Insurance-Related Services Financial Assistance** ☐ Co-payment Assistance ☐ Replacement Medication ■ Benefits Investigation ☐ Appeals Assistance Program ☐ Celgene Free Medication ☐ Fast Track for First □ Prior Authorization/ Program ☐ Transportation Assistance Precertification Assistance Prescription® PATIENT CLINICAL INFORMATION \_\_\_\_\_ Drug and Dosage \_\_\_\_\_ Patient Name Diagnosis/ICD-10-CM Start Date Number of Prior Therapies for This Diagnosis \_\_\_\_\_\_ In Combination With (If applicable) \_\_\_\_\_ Names of Prior Therapies HEALTHCARE PROFESSIONAL/FACILITY INFORMATION Physician Name DEA# Tax ID# Facility Name NPI# PTAN# **Contact Name/Title** Address E-mail City/State/Zip Medicaid Provider # Phone PATIENT INSURANCE INFORMATION If the patient has Medicare, please check all that apply:  $\Box$  Part A  $\Box$  Part B  $\Box$  Part D  $\Box$  Medicare Advantage Medicaid: ☐ Actively Enrolled ☐ Applied/Pending Coverage ☐ Denied (Provide copy of Medicaid denial letter) ☐ Never Applied ☐ I Don't Know **Medical Insurance Company Prescription Drug Plan Name** ☐ Secondary/Supplemental ☐ Veterans Affairs Benefits Name of Insured (Cardholder) Name of Insured (Cardholder) ☐ State Pharmaceutical Assistance Program Policy Name Policy # Group # Policy # Group # Plan Phone Plan Phone Policy Phone BIN# Member ID # Policy # PCN# ☐ Healthcare Marketplace Plan Please copy the front and back of medical insurance and prescription drug plan cards and include with fax or e-mail. I hereby represent, covenant, and certify as follows: (a) I have obtained from my patient all required authorization to release to Celgene Patient Support® and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information; (b) I understand that this information is for the sole use of Celgene Patient Support® and its representatives/agents to assess the patient's eligibility for participation in Celgene Patient Support®; (c) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient by Celgene Patient Support® Free Medication Program or Replacement Medication Program; (d) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Celgene Commercial Co-pay Program for a Celgene product; (e) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify Celgene Patient Support® if I become aver of any such changes; (f) I understand that I am under no obligation to prescribe any Celgene drug and I have not received and will not receive any benefit from Celgene for prescribing a Celgene drug; (g) the information contained in this form is complete and accurate to the best of my knowledge; and (h) I will notify Celgene Patient Support® of any errors regarding the

Please fax to 1-800-822-2496, e-mail to patientsupport@celgene.com,



## Celgene Patient Support® Enrollment Form

Phone: 1-800-931-8691 Web site: www.celgenepatientsupport.com Fax: 1-800-822-2496 E-mail: patientsupport@celgene.com

Online enrollment also available at www.celgenepatientsupport.com

|  | PATIENT INI                                 | FORMATION   |  |
|--|---|---|--|
| Patient's Name   |   | Home Phone  |  |
|  |   |   |  |
| State  | Zip   |   |  |
| Do you permanently reside in   | the US or a US territory? ☐ Yes ☐ No        | Birth Date SS #   |  |
|  | CAREGIVER INFORM                            | MATION (If Applicable)                                    |  |
| Caregiver Name   | Ca  | aregiver E-mail Address                                   |  |
| Caregiver Phone Rel  |   | elationship to Patient                                    |  |
|  | PATIENT FINANCIAL INFORMATIO                | DN (Required for Financial Assistance)                    |  |
|  |   |   |  |
| Patients may be subject to a   | a random audit to verify income. Inco       | me must reflect amount for entire household.              |  |
| Number of people living in h   | ousehold who contribute to or are de        | ependent on your household income:                        |  |
| Average Gross Family Incom   | ne (Numerical value required): \$           | ☐ Yearly ☐ Monthly  |  |
| Please check all that apply:   |   |   |  |
| ☐ Salary/wages   | ☐ Social Security                           | ☐ Earnings from dividends                                 |  |
| ☐ Pension  | ☐ Disability start date _                   | Earnings from rental property                             |  |
|  |   |   |  |
| Celgene Patient Support that provides you and  | port® is a free service<br>d your patients: | Call us at 1-800-931-8691 Monday - Friday, 8 AM - 7 PM ET |  |
| <ul> <li>A single Celgene Patient Support® Specialist<br/>assigned to your office</li> </ul>                           |   | Fax us at 1-800-822-2496                                  |  |
| <ul> <li>Reduced co-pay responsibility of \$25 or less<br/>for eligible patients taking Celgene medications</li> </ul> |   | 1-800-822-2496  Enroll online at                          |  |
| Assistance obtaining insurance approval for<br>Celgene medications   |   | www.celgenepatientsupport.com                             |  |
|  |   | E-mail us at patientsupport@celgene.com                   |  |