CUBICIN® (daptomycin for injection)
INSURANCE VERIFICATION / PATIENT ASSISTANCE FORM

Phone: 866/793-2786
Fax: 866/428-2478

Please complete the form below and fax it to the CUBICIN Reimbursement Hotline at 1-866-4CUBIST or 1-866-428-2478

PRESCRIBER INSTRUCTIONS (please complete)

Service(s) Requested: □ **Insurance Verification/Pre-certification**
□ **Patient Assistance Screening (a copy of the prescribing physician's state medical license is REQUIRED)**

Site of Service: □ **Physician Office** □ **Hospital Outpatient (HOPD)** □ **Hospital Inpatient**
□ **Home Health** □ **Dialysis** □ **Other**

PHYSICIAN/FACILITY INFORMATION (please print)

Physician Name:		**Specialty:**
Facility Name:		
Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
State License #	**Issuing State:**	**Expiration Date:**
Tax ID #:	**NPI #:**	**DEA #:**

CUBICIN PRESCRIPTION INFORMATION (please print)

Dates of Service: (start and stop dates)		**Number of vials requested:**	
Patient weight:	**Dosing (mg/kg):**	**Gender: ❑ M ❑ F**	**ICD-9 Code:**
Facility Name and Shipping Address:			
City:		**State:**	**Zip:**

PATIENT INFORMATION (please print)

US Resident: ❑ Yes ❑ No	**Date of Birth:**	**Phone Number:**	
Patient Name:		**SSN/ID No (Optional):**	
Address:			
City:		**State:**	**Zip:**

INSURANCE INFORMATION (attach a copy of insurance cards, if available) ❑ CHECK IF UNINSURED

Primary Insurance:	**Secondary Insurance:**
Insurance Phone #:	**Insurance Phone #:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Policy Holder's Name:	**Policy Holder's Name:**
Policy Holder's DOB:	**Policy Holder's DOB:**
Policy Holder's SSN (Optional):	**Policy Holder's SSN (Optional):**
MD's Provider # (if applicable):	**MD's Provider # (if applicable):**

FINANCIAL INFORMATION (only complete if applying for Patient Assistance Program)

Can we contact the patient: □ **Yes** □ **No** (Note: A financial interview is required if applying for patient assistance)

Total Adjusted Gross Income: $	**Household Size (include patient):**

REQUIRED SIGNATURES

For Insurance Verification: Patient ***or*** physician signature is required to authorize the release of personal information to Covance for the purposes of conducting insurance research. Please read the Applicant Declaration portion of this form for details on how this information will be used.

For Patient Assistance Program: Patient ***and*** physician signature are required.

Patient: I have read and agree to the Applicant Declaration on the back of this form.

X_____

Signature of Patient or Patient Representative (if signed by Representative, explain authority to act for the Patient)

Patient or Patient Representative Name (print)_____Date_____

Physician: I have read and agree to the terms detailed on the back of this form.

X_____ **Date**_____

Physician's original signature (no stamped signatures)

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APPLICANT DECLARATION

I verify that the information provided in this application is complete and accurate to the best of my knowledge. I authorize my treating physician to disclose to Covance (or other Cubist vendor responsible for operating the CUBICIN Patient Assistance Program) the information requested on the Patient Enrollment Form providing demographic information about me, or the patient whom I represent, (for example, my name, Social Security number, and date of birth), as well as information concerning my health insurance, medical history and current condition, and information about my financial status, and other information as may be reasonably required by Covance that is related to this information (all of this information is referred to as "Personal Information" in this form) for the purposes of determining my eligibility for participation in the CUBICIN Patient Assistance Program or obtaining information on insurance coverage and payment from Cubist. Once my personal information has been disclosed by me or my provider and my health insurer to Covance, federal privacy laws may no longer protect the information from further disclosure. I understand that my treating physician, my insurance company (if any), and Covance will likely need to have oral conversations regarding any or all of this personal information as well, and I hereby authorize such electronic, oral, or written interaction regarding this personal information. I also understand that Covance will not disclose to Cubist any information that identifies me and will only use my personal information for the purposes set forth above.

I understand that I do not have to sign this authorization, but if I do not, Covance will not be able to verify my insurance coverage for CUBICIN or determine if I am eligible to participate in the Patient Assistance Program. My provider and my health insurer will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this authorization. Regardless, I may have to pay for CUBICIN myself. I understand that I may revoke this authorization at any time by mailing or faxing a written request to the treating facility/practice to revoke the authorization, except to the extent that the treating facility/practice has taken action in reliance on my authorization. I also understand that I may inspect or copy the information disclosed pursuant to this authorization.

By submitting this application, the physician agrees to the following:

- Cubist Pharmaceutical's product CUBICIN will be provided to patients in a medically appropriate manner based on current standards of medical care.
- Cubist Pharmaceuticals Patient Assistance Program offers assistance to financially disadvantage patients needing CUBICIN. Patients who are uninsured and unable to afford the cost of therapy may be eligible for enrollment. Cubist Pharmaceuticals reserves the right to change or terminate this program at any time or to refuse to distribute the product under this program to any patient or provider.
- I have prescribed CUBICIN for the patient listed on this insurance verification / patient assistance form. My patient has consented to and authorized my providing you with this information.
- No third party, including Medicaid or other public programs, or patient has been or will be charged for the product for which replacement is sought from Cubist Pharmaceuticals under the CUBICIN Patient Assistance Program. All product received in connection with the CUBICIN Patient Assistance Program will replace product used for the treatment of needy patients who meet the CUBICIN Patient Assistance Program criteria. No part of such replaced product can be claimed as bad debt. No free product will be sold or distributed for sale or used for a different patient.
- The information contained in this form is complete and accurate to the best of my knowledge. If the patient submits written information to the facility/practice that would affect the CUBICIN Patient Assistance Program eligibility, including, but not limited to, revoking the consent that allows the facility/practice to provide patient information under the Patient Assistance Form, the CUBICIN Patient Assistance Program will be notified immediately through telephone at 1-866/RX-DAPTO (866/793-2786), or fax at 1-866/4CUBIST (866/428-2478).