ENZON COVERAGE ASSISTANCE
AND PATIENT ASSISTANCE PROGRAM
Phone: (800) 345-2252 Fax: (888) 625-6587

Patient Information

Name of Patient

Address

City State Zip

( ) Male Female

Phone Number Gender (circle one)

Date of Birth SS#

1. Does the patient have or qualify for prescription drug coverage in any government program? YES ❑ NO ❑
2. Does the patient have or qualify for prescription drug coverage in any private program? YES ❑ NO ❑
3. Is the patient a legal U.S. resident? YES ❑ NO ❑
4. What is the total **ANNUAL** household income, including social security and pension benefits? $ _____ ANNUAL
5. Household size _____

Insurance Information

❑ Please check here if requesting Reimbursement Investigation Only [no PAP]

Primary Insurance

Name Policy # Group #

( )

Phone Number Effective Date

Subscriber's Name Date of Birth

Address

City State Zip

Secondary Insurance

Name Policy # Group #

( )

Phone Number Effective Date

Subscriber's Name Date of Birth

Address

City State Zip

IF REQUESTING PATIENT ASSISTANCE
PLEASE ATTACH A PRESCRIPTION

Therapy Information

Strength Dose Sig.

Quantity Length of Therapy

Diagnosis Information

Primary Diagnosis (ICD9 code plus description)

Secondary Diagnosis (ICD9 code plus description)

Facility Contact [who we should call concerning this request]

Contact Name

( ) ( )

Phone Number Fax Number

Facility and Treatment Information ❑ Shipping Address

Facility Name Facility DEA#

Address

City State Zip

( )

Phone Number Provider ID#

Surgery Date Discharge Date

Patient Statement

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to Enzon and its agents, all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the Enzon Coverage Assistance and Patient Access Program. I also authorize Enzon and its agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate. I understand that Enzon reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize Enzon to use my Social Security number for identification purposes and record keeping only. I have read, understand and agree to all of the above.

Patient's Signature Date

FOR PATIENT ASSISTANCE PROGRAM ONLY

Licensed Prescriber Information ❑ Shipping Address

Name Specialty

Address (PRODUCT SHIPMENT PURPOSES) Provider ID#

City State Zip

( ) ( )

Phone Number Fax Number

DEA# Professional Designation (MD, DO, etc)

( )

Office Contact Name Contact Phone Number

If DEA# is not available, please attach a copy of your state license.

Licensed Prescriber Statement

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Enzon reserves the right to modify or terminate this program at any time. My signature certifies that these goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that Enzon reserves the right to recall the product when necessary.

Licensed Prescriber's Signature Date