

ENZON COVERAGE ASSISTANCE AND PATIENT ASSISTANCE PROGRAM

Phone: (800) 345-2252 Fax: (888) 625-6587

Patient Informa	<u>tion</u>			
Name of Patient				
Address				
City		State		Zip
()		Male	Female	
Phone Number		Gender	(circle one)	
Date of Birth		SS#		
Does the patie government p	ent have or qualify for pres rogram?	cription d		in any
2. Does the patie program?	ent have or qualify for pres	cription d YES 🗖		in any private
3. Is the patient	a legal U.S. resident?	YES 🗅	NO 🗆	
4. What is the to	otal ANNUAL household in	ncome, in	cluding socia	l security and
pension benef	its? \$	ANNU	AL	
5. Household siz	ze			
Insurance Info	rmation Please che	ck here if	requesting R	eimbursement
	Investigat			_
Primary Insura	<u>nce</u>			
Name	Policy #			Group #
() Phone Number		77.00		
Phone Number		Effectiv	e Date	
Subscriber's Nar	me	Date of	Birth	
Address				
City		State		Zip
Secondary Insu	rance			
Name	Policy #			Group #
()				
Phone Number		Effectiv	e Date	
Subscriber's Nar	me	Date of	Birth	
Address				
City		State		Zip
	IF REQUESTING PAT PLEASE ATTACH A			
	Therapy Inf	<u>formati</u>	<u>on</u>	
Strength	Dose			Sig.
Quantity	Length of	Therapy		

Diagnosis Information

Secondary Diagnosis (ICD9 code plus description) Facility Contact [who we should call concerning this request]				
()	()			
Phone Number	Fax Number			
Facility and Treatment In	formation Shipping Addres	<u>ss</u>		
Facility Name	Facility DEA#			
Address				
City	State Zip			
Phone Number	Provider ID#			
Surgery Date	Discharge Date			
physician, or any other health medical records and informat as well as other personal participation in the Enzon Co- authorize Enzon and its agent of the persons or entities list program. I understand that a	arer, either public or private, employer, care provider to disclose to Enzon and its at on, financial and insurance records and information, for the purpose rerage Assistance and Patient Access Programs to disclose all such records and information and patient access to the purpose of my participation only information that reveals my identity with that described above, unless Leive written	gents, all ormation of my n. I also on to any n in thi ll not b		
I hereby authorize any insiphysician, or any other health medical records and informat as well as other personal participation in the Enzon Covauthorize Enzon and its agent of the persons or entities list program. I understand that a used for any purpose other that I verify that the information prunderstand that Enzon reserve the application or modify or criteria. I authorize Enzon to	care provider to disclose to Enzon and its agon, financial and insurance records and info- identifying information, for the purpose terage Assistance and Patient Access Programs to disclose all such records and informationed above for the purpose of my participation	gents, algorithms, algorithms, also on to any n in this ll not be consent curate. Description of the consent curate of modify ligibility tification		
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Licensed Prescriber Statement

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