Reset Form

Ethyol Protect Program®

Phone – 1-800-887-2467 Fax – 1-877-675-6513
P.O. Box 222197 Charlotte, North Carolina 28222-2197

Section 1 – Patient Information

Patient Name_____Date of Birth_____

Address_____Social Security # _____

City _____State _____Zip Code _____

Daytime Phone (___)_____Evening Phone (___)_____

Section 2 – Health Insurance Information

Does the patient have insurance? ☐ **YES** ☐ **NO**

If yes, complete the table below, including all primary and secondary insurance policies.

	Medicare	Medicaid	Commercial	Other
Insurance Company Name				
Policy number				
Group number				
Telephone number				
Policy Holder's name				
Policy Holder's date of birth				

Section 3 – Patient Financial Information

Number In Household (Applicant & Dependents): _____ Total Annual Non-reimbursed Medical Expenses: $_____

Please list total <u>current annual household income</u> for each item listed below. Include all income of persons living in the household:

Salary/Wages	$	Supp. Social Security Income	$
Pensions	$	Social Security Disability Income	$
Social Security Retirement Income	$	Other	$
		Total Annual Income	**$**

Patient Attestation

I verify that the information provided in this application is complete and accurate. I further understand that the Ethyol Protect Program may request documentation to verify financial or insurance information as necessary. I also understand that MedImmune, the sponsor of this program, reserves the right at any time and without notice to modify the application form; modify or discontinue any or all programs; and/or terminate assistance. I understand that this assistance is temporary and that I may be asked to reapply at designated intervals. I agree to inform my physician immediately if my income or insurance status changes.

Patient Signature: _____ **Date:** _____

Section 4 – Facility Information

Physician Name _____ State License Number _____

Site of Service: Hospital Outpatient Clinic ☐ Physician Office/Free Standing ☐ Other (describe) ☐ _____

Facility Name _____ Practice Contact_____

Facility Address_____City _____State/ZIP_____

Phone Number: (_____)_____ Fax Number: (_____)_____

Tax ID Number _____ Provider Number _____

Ethyol® (amifostine for injection) is available in 500mg vials. Please indicate the total number of vials requested/administered: _____

Treatment pathway: Radiation Oncology ☐ Hematology ☐
Medical Oncology ☐ Other (describe) ☐ _____

Diagnosis (please provide code[s]):_____

I attest that the information supplied above is complete and accurate.

Physician Signature: _____ **Date:** _____

Ethyol Protect Program®

PROVIDER SITE AGREEMENT

Physician Name:_____

Facility Name & Address:_____

Contact Person:_____

Facility Phone:_____

Facility Fax: _____

Are you interested in receiving reimbursement news (e.g. updates to your local carrier's coverage guidelines) specific to Ethyol® (amifostine for injection)?

Yes ☐ **No** ☐

If yes, please indicate you how you would like to receive these updates:

☐ **Phone: Phone number & contact name:** _____

☐ **Fax: Fax number & contact name:** _____

☐ **E-mail: E-mail address & contact name:** _____

FOR INSURED PATIENTS:

This Agreement confirms that the purchasing physician or provider site **(Purchaser)** understands and agrees to the following terms of the Ethyol Protect Program for patients who have insurance coverage.

a) That the **Program's** eligibility and insurance coverage requirements are met.
b) Each individual site of service is subject to the **Program's** 18 month eligibility for enrollment in the vial replacement program. After the 18 month window has expired, a site is not eligible to enroll additional patients into the **Program** but may continue to receive other reimbursement support.
c) To obtain written authorization from each patient for the release of patient medical and insurance information and for the use of such information for the purposes of the **Program**, and to provide the **Program** with a copy of the authorization.
d) To complete the enrollment application for each patient and return it to the **Program**.
e) To obtain prior-authorization of Ethyol coverage when required.
f) To take appropriate action to ensure payment from the insurance company, using **Program** assistance as necessary. Such activities may include submitting pre-approval documentation to the insurer, filing claims in a timely fashion, appealing denied claims, or other activities as needed.
g) That in the unlikely event that the approved, **Program**-eligible Ethyol vial(s) is/are not paid for by an insurance company after appropriate claims filing and appeal(s), and thereafter remains unpaid, the **Purchaser** will be eligible for vial replacement, subject to patients meeting financial and other criteria established by the program.
h) To provide documentation of Ethyol purchase in order to obtain the assistance referenced in section (f).
i) If the vials are replaced, the **Purchaser** must return the co-pay or co-insurance collected at the time of service back to the patient.
j) That if the **Purchaser** does not meet the above terms, the vial is no longer covered by the **Program**, and will not be subject to the benefits of the **Program**.
k) To notify the **Program** of any contractual changes with payers that may impact patient coverage.

MedImmune reserves the right to cancel or modify the **Program** at any time.

The individual signing below represents that he or she has the appropriate authority on behalf of the **Purchaser** to enter into this Agreement.

Physician or Site Purchaser Signature:_____**Date:**_____

FOR UNINSURED PATIENTS

I attest that the information supplied is complete and accurate. I understand this information is for the sole use of MedImmune, its representatives, and/or agents selected in order to assess eligibility for participation in the Program. I understand eligibility under this **Program** is subject to approval under the **Program** guidelines, and that MedImmune reserves the right to change or terminate this **Program** without prior notice. I understand that this assistance is temporary and that the patient may be asked to reapply at designated intervals. I agree to inform the Program immediately if I learn that a patient's income or uninsured status has changed. I agree to abide by this certification throughout my participation in the **Program** and to notify the **Program** if aspects of my certification are no longer applicable.

Physician or Site Purchaser Signature: _____ **Date:** _____

ETHYOL®(Amifostine) Protect Program

Consent to Release Information

Your physician wishes to participate in the ETHYOL®(Amifostine) Protect Program. By signing below, you authorize _____ (Physician's Name) to release insurance and basic information about the health of _____ (Patient's Name) to MedImmune Inc., sponsor of the ETHYOL®(Amifostine) Protect Program and manufacturer of Ethyol ("Sponsor"), to its authorized agent the Lash Group, and to its authorized distributors (collectively, the "Participants"). This information will be used to contact a patient's specific insurer or health plan, when appropriate, to determine Ethyol coverage and reimbursement policies, and to conduct inquiries and follow-up on specific Ethyol claims submitted to the insurer or plan on behalf of the patient, and to otherwise determine general eligibility for the Program. By signing below, you also authorize the Participants to make such contacts with the insurer or health plan and to conduct such claims inquiries and follow-up as necessary. The Participants will treat all patient information confidentially, and will use such information only for purposes of administering the ETHYOL®(Amifostine) Protect Program.

I hereby consent to the release of my insurance and clinical information as described above. I also hereby release, on my behalf and on behalf of my successors and assigns, Sponsor and Participants, their officers, directors, employees and agents from any and all claims or liability arising from their conduct pursuant to this consent or the use or disclosure of information relating to Sponsor's or Participants' provision of services as long as such use or disclosure is made in good faith and without malice and conforms to the terms of this consent. I understand that my consent is subject to revocation at any time, except to the extent that action has been taken in reliance on the consent. Unless revoked earlier, this consent shall remain in effect until 365 days from the date of signing this consent.

_____

Signature of Patient

_____

Patient Name (Printed)

_____

Date

☐ A signed copy of this consent form was provided to me for my records.