LIGAND REIMBURSEMENT ASSISTANCE PROGRAM

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line. Return this completed confidential application and prescription to:

LIGAND Reimbursement Assistance Program
PO Box 222197
Charlotte, NC 28222-2197
Telephone: (877) 6LIGAND or (877) 654-4263
Fax: (877) 654-6760

PATIENT INFORMATION

Patient Name: _____

SS#:_____/____/_____ Date of Birth: _____

Patient Language: ___ English ___ Spanish ___ Other _____

Street Address: _____

City, State, Zip: _____

Home Telephone: (____)_____

Work Telephone: (____)_____

For confidentiality purposes, please indicate the number at which you would prefer to be contacted.

__ Home ___ Work ___ Other (___)_____

COVERAGE AND INSURANCE

If you do not have insurance, please indicate "No Insurance" on the first line.

Primary Insurance

Health Insurance Company:_____

Telephone:(____)_____ Provider ID Number:_____

Policy ID Number: _____Group Number:_____

Subscriber Name: _____Date of Birth:_____

Does this policy cover prescription drugs? ☐ YES ☐ NO

Do you have any **secondary insurance**, including **Medicare**?

☐ YES ☐ No

(If yes, please provide name, telephone number, and policy number)

_____

_____

Have you applied to **Medicaid**? ☐ YES ☐ NO

If YES, date of application:_____

Are you eligible? ☐ **YES** ☐ **NO**

If not eligible, reason for denial:_____

FINANCIAL INFORMATION

Current annual household income $_____

Source of income: ____ Job ____Family

____ Public Assistance (SSI/SSDI)

Number of household members dependent on income stated above (include applicant)_____

Other (Please explain):_____

APPLICANT DECLARATION

I verify that the information provided in this application is complete and accurate. I further understand that the LIGAND Reimbursement Assistance Program may request documentation to verify financial or insurance information. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that LIGAND reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the LIGAND Reimbursement Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

Patient Signature_____Date_____

PHYSICIAN INFORMATION

This section is to be completed by the physician only.

Patients who qualify for assistance will receive free product shipped to the physician's office/clinic. Please attach the patient's prescription to this application.

Physician Name: _____

Facility Name: _____

Street Address: _____

City: _____State: _____Zip: _____

Tel: _____Fax: _____

DEA #: _____ **State License #:** _____

Tax ID Number: _____

Office Contact Name_____

(e.g. nurse, social worker or other representative we should contact regarding this patient.)

Prescribing Information:

Ligand Drug Requested*: _____

Patient ICD-9-CM Diagnosis code:

_____

Dosage: _____ Patient Weight: _____kg

I certify that the requested LIGAND product is medically necessary for this patient and I will be supervising the patient's treatments.

Signature_____ **Date**_____

As part of your patient's eligibility, you will be asked to periodically verify continued use of the requested LIGAND product and resubmit a current prescription.

***Ligand Products**

Ontak® (denileukin diftitox) – Indicated for the treatment of patients with persistent or recurrent cutaneousT-cell lymphoma whose malignent cells express the CD25 component of the IL-2 receptor.

Panretin® gel (alitretinoin) – Indicated for topical treatment of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma.

Targretin® gel (bexarotene) – Indicated for the treatment of cutaneous lesions in patients with CTCL (Stage 1A and 1B) who have refractory or persistent disease after other therapies or who have not tolerated other therapies.
Targretin® capsules – Indicated for the treatment of cutaneous manifestations of CTCL in patients who are refractory to at least one prior systemic therapy.

LIGAND®
PHARMACEUTICALS