Sigma-Tau Patient Assistance Program
200 Pinecrest Plaza
Morgantown, WV, 26505-8065
Phone: (800) 490-3262
Fax: (866) 694-2544

Application Instructions

Program Eligibility:

The patient cannot have or qualify for any prescription coverage for Abelcet® or DepoCyt® including all federal, state and local programs (such as Medicare, Medicaid, TriCare etc).

Patient's total annual household income must be at or below 300% of the current Federal Poverty Guidelines (Proof of Income is required – Federal Income Tax Return).

Assistance Available to Eligible Patients:

Providers treating eligible patients can receive replacement product to cover outpatient or inpatient treatment administered from the date of program eligibility through 90 days, based on the prescription provided by the physician. A patient being treated as an inpatient or outpatient may apply for retroactive assistance within 45 days of the first initial treatment date. If eligible, a 90-day supply may be provided from the first treatment date. **Re-application is required for assistance over 90-days.**

PAP Instructions:

Please complete the application in its entirety. Missing or incomplete information will delay application processing.

The patient must sign the **Patient Statement Section**.

The practitioner must complete and sign the **Prescription** and **Practitioner Statement Section**.

The prescription information for the treatment requested must be indicated on the attached application. Physician orders and treatment records will be accepted for inpatient requests and for outpatient treatment that has taken place within 45 days of application.

Approved product cannot be shipped without a validated State License Number for the receiving practitioner or facility. Accurate State License Numbers for both the practitioner and the receiving facility are required on the application. Please be advised that if State License Numbers cannot be validated, a copy of the State License or a Letter of Affiliation will be required.

Fax the completed application for the brand name product up to a maximum 3-month supply to: **(866) 694-2544.**

Reset Form

sigma-tau PHARMACEUTICALS, INC.
Rare dedication

Sigma-Tau PATIENT ASSISTANCE PROGRAM Application

Phone: (800) 490-3262 Fax: (866) 694-2544

Patient Information

Name of Patient	Male Female **Gender (circle one)**	/ / **Date of Birth**

Address	**City**	**State**	**Zip**

( )

Phone Number	**SSN#**

Primary Diagnosis (ICD10 code with description)	**Secondary Diagnosis (ICD10 code with description)**

Area of Care (Oncology, ICU, CCU, Solid Organ Transplant)	**Surgery Date**	**Discharge Date**

Does the patient have or qualify for health insurance benefits in any government program? YES ❑ NO ❑

Does the patient have or qualify for health insurance benefits in any private program? YES ❑ NO ❑

What is the patient's residency status? Permanent Resident ❑ Temporary Resident ❑

What is the total **ANNUAL** household income, including social security and pension benefits? $_____ ANNUAL

Household size _____

INSURANCE INFORMATION

❑ **Check if uninsured**

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**

PATIENT STATEMENT

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to Sigma-Tau 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 Sigma-Tau Coverage Assistance and Patient Access Program. I also authorize Sigma-Tau 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 Sigma-Tau 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 Sigma-Tau 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**

Health Care Provider Information and Prescription

FACILITY INFORMATION ❑ **Check if Shipping Address**

Facility Name **Address**

( )

City **State** **Zip** **Phone Number**

Facility State License # **Facility Tax ID#**

( ) **( )**

Facility Contact Name **Contact Phone Number** **Contact Fax Number**

PRESCRIBING PHYSICIAN INFORMATION ❑ **Check if Shipping Address**

Name **Professional Designation (MD, DO)** **Specialty**

Name of Practice **Address**

City **State** **Zip**

( ) **( )** **@**

Phone Number **Fax Number** **Email address**

DEA# **Prescriber State License #** **Tax ID #**

PRESCRIPTION **This is the prescription. Physician must complete the prescription below. Please print.**

Physician orders and treatment records will be accepted for retroactive treatment when submitted within 45 days of the first initial treatment date. Please refer to instructions.

Date____/_____/_____

Patient's Full Name _____ **Patient's Date of Birth** ____/_____/_____

Product: ❑ **Abelcet** ❑ **DepoCyt**

Strength _____ **Dose**_____

Directions _____

Length of Therapy _____

❑ **Inpatient Treatment** ❑ **Outpatient Treatment**

➢ **Prescribing Physician's Signature (no electronic signature or stamp)**

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 Sigma-Tau 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 Sigma-Tau reserves the right to recall the product when necessary.

➢ **Licensed Prescriber's Signature (no electronic signature or stamp)** **Date**