Patient Enrollment Form

Complete and fax to 1-866-930-1562

PO Box 220551, Charlotte, NC 28222-0551
Phone: 1-888-53-STAR7 (888-537-8277)
SpectrumPatientAccess.com

Please check the drug(s) for which you are requesting assistance.

____ BELEODAQ® (belinostat) for injection
____ FOLOTYN® (pralatrexate injection)
____ FUSILEV® (levoleucovorin) for injection
____ MARQIBO® (vinCRIStine sulfate LIPOSOME injection)
____ ZEVALIN® (ibritumomab tiuxetan) injection for intravenous use

I'm requesting assistance with the following issue:

____ Verification of Insurance Benefits/Drug Coverage
____ Coding Question (i.e. HCPCS, National Drug Code)
____ Apply for STAR Patient Assistance Program (PAP) if uninsured
____ Apply for Co-Pay Assistance (for privately-insured patients only)
____ Denied/Underpaid Claims Assistance ____ Other ________________

PATIENT INFORMATION

First Name:	Last Name:	
Correspondence Address:		
City:	State:	ZIP:
SSN:	Date of Birth:	Telephone:
Gross Annual Household Income: $	Is patient a U.S. Citizen or legal U.S. resident? ❑ **YES** ❑ **NO**	

INSURANCE INFORMATION - Please provide copies of all medical and pharmacy insurance cards (front and back)

Does the patient have medical benefits and/or pharmacy benefits through any private or government health insurer/payer/program? ❑ **YES** ❑ **NO** If "YES", please complete all that apply below:

Type of Insurance - "X" if Yes	*Name of Insurer/Plan*	*Policy ID #:*	*Group # (if applicable)*	*Insurance Phone #*
❑ Medicare Part A				
❑ Medicare Part B (Fee-for-Service/Original Medicare)				
❑ Medicare Part C - (Medicare Advantage)				
❑ Medicare Part D - Drug Plan				
❑ Private Insurance - Medical (Primary)				
❑ Private Insurance - Medical (Secondary)				
❑ Private - Pharmacy Benefits Manager				
❑ Medicaid				
❑ Veterans Affairs				
❑ TRICARE				
❑ Other insurance				

PHYSICIAN INFORMATION

Referring Physician Name:	State License #:	NPI:
	Tax ID #:	PTAN:
Facility Name and Street Address:		
City:	State:	ZIP:
Office Contact:	Phone:	Fax:
List Patient Diagnosis and ICD-10-CM code(s):		
Treating Physician Name:	State License #:	NPI:
	Tax ID #:	PTAN:
Facility Name and Street Address:		
City:	State:	ZIP:
Office Contact:	Phone:	Fax:

Prescription for Patient Above - Check applicable drug.	**Dosage per treatment:**	**Frequency:**	List planned/future outpatient dates of service for drug:
❑ BELEODAQ® (belinostat) for injection ❑ FOLOTYN® (pralatrexate injection) ❑ FUSILEV® (levoleucovorin) for injection ❑ MARQIBO® (vinCRIStine sulfate LIPOSOME injection) ❑ ZEVALIN® (ibritumomab tiuxetan) injection for intravenous use			

Patient Authorization and Release to Collect, Use and Disclose Certain Information:

By signing below, I verify that the information provided is complete and accurate. Furthermore, I authorize the disclosure and use of my financial information, insurance information, medical information, including personally identifiable protected health information to and by the STAR program for the purpose of allowing the STAR program to provide me with reimbursement support services, patient assistance support, and/or copay-assistance, and to evaluate me for eligibility in the STAR program. I also authorize my physician(s), pharmacist(s), other healthcare providers, patient advocacy organizations, and insurance companies to disclose to the STAR program, and the companies that help administer the STAR program, information about my medical condition, treatments, financial information, insurance status, and protected health information for the purpose of providing STAR services and assistance. Once my information has been disclosed, I understand that federal privacy laws may no longer protect that information. Additionally, I understand that nonidentifiable information from all STAR participants may be summarized for statistical or other purposes, but my identity cannot be determined from this summary information. By signing below, and enrolling in STAR, I hereby (i) authorize any and all disclosures of my identifiable health/financial/insurance information as set forth in this paragraph, and (ii) consent to such disclosure. I understand I may revoke this authorization by giving written notice of my revocation to STAR at the address above. I understand my revocation of this authorization will not affect any action STAR took in reliance on this authorization before STAR received my written notice of revocation.

PATIENT and PHYSICIAN SIGNATURES

Patient Name (print) ________________________ Patient Signature (required) ________________________ Date ____________

Legal Representative/Guardian Signature (If applicable) ____________________________ Date ____________

Prescribing Physician Name (print) ____________________ Prescribing Physician Signature (required) ____________________ Date ____________

Please see Important Safety Information on page 2 for MARQIBO and page 3 for ZEVALIN.
Please see the accompanying full Prescribing Information, including BOXED WARNINGS for MARQIBO and ZEVALIN.