Wyeth

Mylotarg® (gemtuzumab ozogamicin for injection) & Neumega® (oprelvekin)
Reimbursement Support and Patient Assistance Programs
PO Box 220907, Charlotte NC 28222-0907
Phone: 866-993-8466 Fax: 866-993-8411
Patient Enrollment and Application Form

Reset Form

All items must be completed. This form may be used to inquire regarding Patient's coverage for Mylotarg or Neumega, or to apply for the Patient Assistance Program. Please be sure to include both patient and physician signatures below.

Requested services: ☐ Insurance Verification* ☐ Patient Assistance Program

Physician Information

Physician Name: _____ Site Name: _____

Select One: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other

Practice Address: _____ City, State, ZIP: _____

Contact Name: _____ Phone #: _____ Fax #: _____

Treatment Information

Dosage: _____ Treatment Start Date: _____

Product Shipping Address/Infusion Site (If different from above) _____

Patient Information

Patient Name: _____ Social Security # _____ Male ☐ Female ☐

Address: _____ City, State, ZIP: _____

Daytime Phone #: _____ Date of Birth: _____

Patient Insurance Information

☐ I have no insurance coverage, including Medicaid or Medicare (Skip to Public Programs Section).

Primary Insurance Information (including Medicaid or Medicare)

Payer Name: _____

Policy #: _____ Group #: _____

Payer Phone #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance Information

Payer Name: _____

Policy #: _____ Group #: _____

Payer Phone #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Public Programs

Have you applied for Medicaid, Medicare or other public assistance programs?

☐ **Yes** Program Name: _____ Date Applied: _____

Status of Application: ☐ Approved ☐ Pending ☐ Denied (If denied, please enclose copy of denial)

☐ **No** Do you intend to apply? ☐ Yes ☐ No If not, why? _____

Financial Information

Annual Household Income (gross): _____ Number of household members dependent on income: _____

Patient and Physician Declaration

I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. If Patient is applying for Patient Assistance Program, I certify that Patient is a U.S. resident, and has no government or private insurance to pay for the medication requested, and that paying for the medication from Patient's own resources or assets would cause Patient severe financial hardship. I agree that if this application is approved, the medication will be provided to Patient free of charge, and I will not submit a claim for reimbursement to or collect reimbursement from patient or any third party for the medication. Patient has provided a valid HIPPA authorization for to Physician pertaining specifically to the Program, which Physician maintains. Patient authorizes Wyeth and its agents to utilize personal information to administer Patient's participation in the Program. I understand that, at any time, Wyeth may modify or discontinue any or all of the Program and related eligibility criteria, or terminate assistance provided by the Program. I have read and understand the Program guidelines and agree to comply with program requirements.

Patient Signature **Date** **Physician Signature** **Date**

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Mylotarg® (gemtuzumab ozogamicin for injection) & Neumega® (oprelvekin) Reimbursement Support and Patient Assistance Programs
Physician Enrollment Form

Please complete this form and fax to the Mylotarg & Neumega Reimbursement Support and Patient Assistance Programs at 1-866-993-8411. Your completion of this form will facilitate future program requests. To inquire regarding your patient's coverage for Mylotarg or Neumega, or to apply for the Mylotarg & Neumega Patient Assistance Program, please submit a completed Patient Enrollment and Application Form.

Mylotarg & Neumega Reimbursement Support and Patient Assistance Program
PO Box 220907 Charlotte NC 28222-0907
Phone: 866-993-8466 Fax: 866-993-8411

Physician Information

Physician Name:	**Office Contact Name:**
DEA #:	**Tax ID #:**
State License #:	**National Provider ID #:**
Facility/Practice Name:	**Street Address:**
City:	**State:** **Zip Code:**
Phone #:	**Fax #:**
Shipping Address/Infusion Site (If different from above)	

Physician Declaration

By signing below, I agree on my behalf and on behalf of the facility referenced above to the following:

- I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. I have read and understand the Program guidelines and agree to comply with program requirements. I understand that, at any time, Wyeth may modify or discontinue any or all of the Program and related eligibility criteria, or terminate assistance provided by the Program.
- I understand that medication provided under the Patient Assistance Program is provided free of charge to eligible patients.
- I understand that I may seek replacement for Mylotarg or Neumega that has been administered to a patient who then has his or her insurance claim denied after an appeal. If the patient met the other eligibility criteria for the Patient Assistance Program at the time the medication was administered, the product the patient received may be replaced. I understand that product replacement may be available only for fully denied, not underpaid claims, and excludes any procedure, service or other cost related to the administration of the drug. I understand that documentation of insurance denial and appeal are required, and I agree to provide such documentation.
- I certify I will not charge any patient or any third party for medication provided under the Patient Assistance Program, including medication that is replaced.
- I understand that if a patient's insurance status changes, the patient may no longer be eligible under the Program and I agree to immediately notify the Program if I become aware of changes in the patient's insurance status.
- I agree that if retroactive insurer policy change or decision provides reimbursement for free medication provided or replaced, I will immediately notify the Program and the Program will bill for the medication or arrange for billing.
- I understand that I am under no obligation to prescribe any drug and that I have not received nor will I receive any benefit from Wyeth for prescribing any Wyeth drug.
- I understand that the Program is not responsible for filing any insurance claims and provides no guarantee of payment.
- I agree to abide by this certification throughout my participation in the Program and notify immediately a Program representative if any aspects of my certification are no longer applicable.

Physician Signature **Date**