Wyeth/Genetics Institute MYLOTARG™ and NEUMEGA® Patient Assistance Intake Form

Drug: MYLOTARG NEUMEGA

Phone 888-638-6342 FAX: 866-836-0819

Patient Name:	Home Phone:
Mailing Address:	
City:`	State:
Zip Code:	
Insurance Name: #1:	ID#:
Group #:	Plan #:
Insurance phone	
Insurance Name #2:	ID #:
Group #:	Plan #:
Insurance phone	
Insurance Name # 3:	ID #:
Group #:	Plan #:
Insurance phone	
Physician Name:	Phone Number:
Street Address	City:
State:	Zip Code:
SS # :	Marital Status:
Referral source:	Sex:
DOB:	Spouse's name:
	Dosage:
Income Information	
Work $:	Savings $:
Social Security $:	IRA $:
CD $:	Pension $:
Mutual Funds $:	Stocks $:
Bonds $:	Own Home or Rent:
Other Property: NO YES (value)	Veteran: YES NO
Union: YES NO	Household Size:
Do you receive or have you applied for state assistance: (if yes, specify type and where applied)	

The patient is required to provide documentation of the above.

Wyeth/ Genetics Institute-Oncology Physician/Hospital Application Form

Physician Information
DEA Shipping Address

Organization Name	**Physician Name (Include Professional Designation)**
Shipping Address Line 1	**DEA Number**
Shipping Address Line 2	**Application Contact**
City, State, Zip	**Phone Number-Fax Number**

Physician or Hospital Certification

I agree to provide my patients with the Program information as provided by Wyeth/ Genetics Institute. I authorize the release of patient identification and insurance information. I understand it is for the sole use of Wyeth/ Genetics Institute, its representatives, and /or agents selected to access my patient's eligibility for participation in the program. I certify that my requests for assistance is because insurer denial of claim. I will seek credit or replacement for the Wyeth/ Genetics Institute drug administered to my patients. I understand documentation of insurance denial and appeal may be required and I agree to provide such documentation. I understand that an application to this Program is subject to approval under the Program guidelines and that Wyeth/ Genetics Institute reserves the right to change or terminate this Program without prior notice. I understand that patient assistance is temporary and available only for fully denied, not underpaid claims, and excludes any procedure, service or other cost related to the administration of the Program drug. I understand that if the patient's insurance status changes, the patient may no longer be eligible under this Program and I agree to notify immediately a Program representative if I become aware of changes in the patient's insurance status.

I certify that no free drug provided under this program will be sold or redistributed to any individual or organization. I certify I will not charge Program patients or payers for any Wyeth/ Genetics Institute drug for which I receive credit or replacement vials. I agree that if a retroactive insurer policy change provides reimbursement for any Wyeth/ Genetics Institute drug credited or replaced, I will immediately notify a Program representative and the Program will bill for the drug or arrange for billing through a Program participating wholesaler. I certify I am currently licensed to prescribe and receive the drug specified on the application. I understand that I am under no obligation to prescribe any drug that I have not received nor will I receive any benefit from Wyeth/ Genetics Institute or Documedics, Inc., for prescribing an Wyeth/ Genetics Institute drug. I understand that Documedics, Inc. and Wyeth/ Genetics Institute are not responsible for filing any insurance claims. 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.

Original Signature of Physician
Date:
Mail/Fax Completed Application copy of DEA certificate to:

Lash Group
PO Box 1285
San Bruno, CA 94066

Phone: (888)-638-6342
FAX: 866-836-0819

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I have requested assistance from Lash Group in determining whether my prescription for Neumega® (oprelvekin) is covered under my current health insurance plan and, if applicable, to determine my eligibility for participation in the Neumega Patient Assistance Program ("Programs"). I understand that Lash Group needs certain information about me to provide these services. Therefore, I request and authorize my doctor, _____________ ("Doctor") and my health insurance company ______________ ("Insurer") to give [Lash Group, including representatives who work on behalf of Lash Group in these Programs] information about my health care treatment and insurance coverage. The type of information that may be given to Lash Group includes information that identifies me, such as my name, address, social security number, diagnoses, prior treatments, and information about my health insurance benefits.

I understand that I may decide not to sign this authorization, and that my decision not to sign it will not affect my ability to obtain treatment or to seek payment for treatment. However, Lash Group will be unable to provide me with the services I have requested.

I understand that I can cancel this authorization at any time by writing to my Doctor at ___________________[address] or my Insurer at ________________[address]. If I cancel this authorization, then my Doctor and Insurer will not provide Lash group with any further information about me, and Lash Group will no longer be able to provide me with the assistance I have requested.

I understand that once my Doctor and Insurer give Lash Group information about me based on this authorization, federal privacy laws do not prevent Lash Group from further disclosing my information. However, I also understand that Lash Group has agreed that it will only use or disclose information provided by my Doctor and Insurer to assist me in determining whether my prescription is covered under my current health insurance plan or for determining my eligibility for participating in the Neumega Patient Assistance Program or for the administration of the Programs. I also understand that in the event of an audit and only for purposes of such an audit, some information may also be disclosed to Wyeth (the manufacturer of Neumega).

This authorization is good for three (3) years from the date signed below.

A copy of this signed form will be sent back to me for my records.

Patient or Personal Representative of Patient

____________________________________ ____________________________

Signature **Date**

____________________________________ ____________________________

Name (*Please Print*) **Authority to sign on behalf of Patient**