



**Fax Completed Form To 1-800-822-2496**

If you have any questions regarding this form, please call 1-800-931-8691.

**APPLICATION FOR PATIENT ASSISTANCE  
FAX COVER SHEET**

<b>TO:</b>	<b>FROM:</b>
<b>FAX: 1-800-822-2496</b>	<b>YOUR FAX:</b>
<b>PHONE: 1-800-931-8691</b>	<b>YOUR PHONE:</b>
<b>RE: (PATIENT'S NAME)</b>	<b>DATE:</b>

**This application is *REQUIRED* for assistance with the following reimbursement services:**

- Uninsured and Underinsured Patient Assistance/Free Drug
- Appeal Assistance (***Please attach a copy of insurance company denial letter***)
- Celgene Commercial Co-Pay Program (for IV products)

**This application is *NOT REQUIRED* for assistance with the reimbursement services listed below.**

*For assistance with the reimbursement services listed below you can contact Celgene Patient Support® directly at 1-800-931-8691 or you can complete this application and submit it to Celgene Patient Support®.*

- Celgene Commercial Co-Pay Program (Other)
- Co-payment/Co-insurance assistance referrals
- Benefit Investigation
- Other (please specify) \_\_\_\_\_

**For all submitted applications, please include all that apply:**

- Physician or Healthcare Provider's signature on the Physician form
- Patient or Patient Representative signature on the Patient form
- Documentation of Power of Attorney, if applicable
- Copies of the front and back of insurance cards

**Confidentiality Note:** This message is strictly confidential and contains legally privileged material. It is intended only for the use of the addressee(s) named above. Dissemination, distribution, copying or use of this message, other than by such addressee(s), is strictly prohibited. If you have received this message in error, please immediately notify us by telephone at 1-800-931-8691 and return the original to us at the address above.



# Patient Assistance Application

- New**  
 **Renewal**

For assistance with reimbursement services please call Celgene Patient Support® 1-800-931-8691.

**THIS PAGE TO BE COMPLETED BY PHYSICIAN OR HEALTHCARE PROVIDER  
 FAX COMPLETED FORM TO 1-800-822-2496**

**Please check all that apply:**

**Application required for the below services:**  Appeal assistance (*Please provide copy of insurance payer denial letter*)  
 Underinsured and Uninsured Patient Assistance/Free drug  Celgene Commercial Co-Pay Program (for IV products)

**Application not required for the below services, please contact Celgene Patient Support® for assistance**  Benefit investigation  
 Celgene Commercial Co-Pay Program (Other)  Co-payment/Co-insurance assistance referrals  Other \_\_\_\_\_

## CLINICAL INFORMATION

**PATIENT NAME** \_\_\_\_\_ **DRUG** \_\_\_\_\_ **START DATE** \_\_\_\_\_  
**DIAGNOSIS/ICD-9-CM** \_\_\_\_\_ **DOSAGE** \_\_\_\_\_  
**NUMBER OF PRIOR THERAPIES FOR THIS DIAGNOSIS** \_\_\_\_\_ **IN COMBINATION WITH (IF APPLICABLE)** \_\_\_\_\_  
**NAMES OF PRIOR THERAPIES** \_\_\_\_\_

PHYSICIAN NAME	DEA #	TAX ID #
CLINIC NAME	NPI #	PTAN #
MAILING ADDRESS	MEDICAID PROVIDER #	
CITY/STATE/ZIP	CONTACT EMAIL	
CONTACT NAME	CONTACT PHONE & EXT #	
CONTACT TITLE	CONTACT FAX #	

## PATIENT INSURANCE INFORMATION

If the patient has **Medicare**, please check all that apply:  **Part A**  **Part B**  **Part D**  **Medicare Advantage**  
**Medicaid:**  **Denied/Not Eligible (Please provide copy of denial letter)**  **Not applied**  **Pending Coverage**  
*(Please include copies of patient's insurance cards, front & back)*

<b>Medical Insurance Company</b>	Policy & Group Number	PCN Number
Name of Insured (Holder)	Plan Phone Number	Other
<b>Prescription Drug Plan Name</b>	Policy & Group Number	PCN Number
Name of Insured (Holder)	Plan Phone Number	Bin Number
<b>Other</b> <input type="checkbox"/> Secondary/Supplemental <input type="checkbox"/> Veterans Affairs Benefits <input type="checkbox"/> State Pharmaceutical Assistance Program	Policy Name & Phone Number	Policy Number

I hereby represent, covenant and certify as follows: (a) I have obtained from my patient all required authorization to release to Celgene Patient Support® and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information, (b) I understand that this information is for the sole use of Celgene Patient Support® and its representatives/agents to assess the patient's eligibility for participation in Celgene Patient Support®, (c) I have not received, nor will I seek or accept reimbursement for any drug provided for my patient in Celgene Patient Support®, (d) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program, and I will notify Celgene Patient Support® if I become aware of any such changes, (e) I understand that I am under no obligation to prescribe any Celgene drug and I have not received and will not receive any benefit from Celgene for prescribing a Celgene drug, (f) the information contained in this form is complete and accurate to the best of my knowledge, and (g) I will notify Celgene Patient Support® of any errors regarding the foregoing, and will make every effort to correct those errors.

**PHYSICIAN OR HEALTHCARE PROVIDER SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



# Patient Assistance Application

- New
- Renewal

This application may be subject to random audit of income and asset information.

## THIS PAGE TO BE COMPLETED BY PATIENT OR GUARDIAN FAX COMPLETED FORM TO 1-800-822-2496

PATIENT'S NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_  
 STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PHONE NUMBER \_\_\_\_\_  
 EMAIL \_\_\_\_\_

Do you permanently reside in the U.S. or a U.S. territory?  
 Yes  No  
 SEX:  FEMALE  MALE  
 MARITAL STATUS:  SINGLE  MARRIED  WIDOWED  
 BIRTH DATE \_\_\_\_\_  
 SS # \_\_\_\_\_  
 NUMBER OF PEOPLE LIVING IN HOUSEHOLD \_\_\_\_\_  
**(Number of people who contribute to or are dependent on your household income)**

**Average Monthly Gross Family Income:**  
 (complete only if requesting free drug or financial assistance)

\$ \_\_\_\_\_ (required)  
 (Value should reflect amount for entire household)  
**Numerical value required. DO NOT LEAVE BLANK.**

**Please check all that apply:**

Salary/wages  Disability  
 Pension  Earnings from dividends  
 Social Security  Earnings from rental property

**Total Family Assets:**  
 (complete only if requesting free drug or financial assistance)

\$ \_\_\_\_\_ (required)  
 (Value should reflect amount for entire household)  
**Numerical value required. DO NOT LEAVE BLANK.**

**Please check all that apply:**

Savings, checking, money market accounts  Estimated market value of stocks, mutual funds  
 CDs  Estimated market value of bonds  
 Estimated market value of IRAs

**(Do not include: household items, personal property, house, car)**

To the extent necessary to process and administer my Celgene Patient Support® application, in connection with all Celgene Patient Support® services, I hereby:

1. Appoint Celgene Patient Support® and its agents\* as my personal representatives with authority to act on my behalf with respect to this application.
2. Authorize Celgene Patient Support® and its agents to contact my healthcare providers, health plans, insurers, other potential city, county, state or federal funding sources, social workers and patient advocacy organizations (collectively the "Agencies") on my behalf to request information for my Celgene Patient Support® application.
3. Direct Agencies to recognize the Celgene Patient Support® and its agents as my personal representatives for this application.
4. Direct Agencies to release, in electronic or other form, to the Celgene Patient Support® Specialist and its agents such information (including without limitation, relative to my medical condition, treatment or drug therapy) as requested by Celgene Patient Support® and its agents for this application.

I understand that Celgene Patient Support® and its agents will request only that information needed to process and administer this application, and that they will not disclose the information they obtain, except as needed for this purpose or as required by applicable law.

\*Agents may include third-party reimbursement service providers.

I hereby represent, covenant and certify as follows: (a) the medical and insurance information in this form is provided with my consent, (b) the information contained in this application is complete and accurate to the best of my knowledge, (c) I understand that if my prescription drug plan coverage changes or if my financial status changes, I may no longer be eligible under this program, and I will promptly notify Celgene Patient Support® of any such changes, (d) in the event that I become eligible for a benefit through a federal, state or private program which may reimburse for the medication requested I will notify Celgene Patient Support® and understand that I may no longer be eligible for assistance, (e) upon the request of Celgene Patient Support® and/or its agents/representatives I will provide documentation, including but not limited to personal financial records, to verify the information contained in this application, (f) I understand that if there is a determination at any time that I am no longer eligible for this program Celgene may immediately stop any assistance provided under this program, and (g) I will notify Celgene Patient Support® of any errors regarding the foregoing, and will make every effort to correct those errors.

**PATIENT OR GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

PATIENT OR PATIENT REPRESENTATIVE NAME \_\_\_\_\_ (PLEASE PRINT)

**If signed by Patient Representative, please fax documentation of Power of Attorney.**