

Berlex Oncology CamCare™ Application Form

Phone: (800) 473-5832 Fax: (800) 513-1824
 PO Box 221289 Charlotte NC 28222-9910

PROGRAM TYPE (PLEASE CHOOSE ONE)

Drug Replacement Program
 Please complete sections 1-3 and 5

Patient Assistance Program
 Please complete sections 1-5

SECTION 1 – PHYSICIAN PORTION

Physician Name _____ State License # _____ DEA# _____
 Name of Group/Hospital _____ Tax ID # _____
 Correspondence Address _____
 City _____ State _____ Zip Code _____
 Telephone _____ Fax _____
 Office Contact Name and Extension _____
 Ship Address (if different than above) _____
 City _____ State _____ Zip Code _____

Berlex Product (indicate drug and number of vials requested):

Campath (alemtuzumab) 30 mg # of vials _____ Fludara (fludarabine) 50mg # of vials _____ Leukine (sargamostim) # of vials _____
 Dose _____ Route of Administration _____
 Dosing Regimen _____ Site of Service _____
 Treatment Starting Date _____ Treatment Completion Date _____
 Patient's Diagnosis (including ICD-9 code) _____

Physician certification: I understand that I agree to follow this patient through his/her entire course of Campath/Fludara/Leukine therapy. I understand that I will be sent vials once I have provided all requested documentation in a timely manner to Berlex or its agents regarding therapy with Berlex products for this patient.

Physician Signature _____ Date _____

SECTION 3 – HEALTH INSURANCE INFORMATION

Do you have any type of health insurance, including public programs such as Medicare, Medicaid, or any other assistance programs?

Yes No (If yes, complete the table below, including all primary and secondary insurance policies.)

	Medicare	Medicaid	Commercial	Other
Insurance Company Name				
Policy Number				
Group Number				
Telephone Number				
Policy Holder's Name				
Policy Holder's Date of Birth				

Has coverage for therapy been specifically denied? Yes No
 If yes, please state the reason _____

SECTION 4 – FINANCIAL/OTHER INFORMATION (TO BE COMPLETED ONLY IF PATIENT HAS NO INSURANCE)

Financial Information

Current Annual household gross income \$ _____

Number of household members dependent on income stated above (include applicant) _____

Out-of-Pocket Medical Expenses \$ _____

Other Information

Are you a veteran of the U.S. Armed Forces? Yes No

Do you reside in the U.S. or U.S. territory and meet residency criteria for some form of potential public assistance? Yes No

Medicaid

Have you ever applied to Medicaid? Yes No

If No, please explain why you have not applied. _____

If Yes, and your application was rejected, explain reason for rejection. _____

SECTION 5 – PATIENT CONSENT AND AUTHORIZATION

I certify that all of the above statements and any information provided are correct and that I understand eligibility under this program are subject to Berlex's approval. I grant Berlex or its agents the right, at all times, to investigate any and all claims made under this program. I agree that Berlex Corporation, or its representatives, and/or any organization selected by Berlex Corporation to represent it, may see, or get a copy of, all medical, prescribed drug, and insurance coverage records from my healthcare provider or my insurance company which pertain to treatment with Berlex's product for:

Print Patient's Name

This information is for the sole use of Berlex Corporation and/or its representatives. Unless required law, information will not be given in an identifiable form to any other persons unless the patient agrees to its release in writing. This authorization will become effective when signed below and will remain in effect until revoked by the patient. A photocopy of this form is as valid as the original.

Signature of Patient or Legal Representative _____
Date

NOTE: Berlex reserves the right to limit or modify in whole or in part the Patient Assistance Program, specific to any patient or provider, or terminate the program, at any time without further notification. In addition, no patient will be accepted into the program without the provider's or patient's (or legal representative's) original signature on this form. Berlex reserves the right to make a separate, independent determination of patient eligibility.