ENROLLMENT APPLICATION: Aloxi Alliance Reimbursement, Patient Assistance Program and Insurance Verification Program

PRESCRIBER INSTRUCTIONS

IMPORTANT: Please provide the physician's State License or DEA number and expiration date.

1. For consideration to determine if your patient is eligible for the ALOXI Alliance Reimbursement Program please complete the application form.
2. Request that the patient complete page two of the application. Forward the form to the address or fax indicated on the form.
3. **Financial information is NOT needed for a simple insurance verification.** However, if applying for the Patient Assistance Program, a financial interview with the patient or physician office is required and income verification documentation will be requested during the financial interview.
4. MGI PHARMA will determine if your patient is eligible for patient assistance or if they have reimbursement to cover Aloxi™.
5. If the patient is eligible to participate in the Patient Assistance Program, both you and the patient will receive a letter of acceptance. There will be no charge to your patient. The first shipment of Aloxi™ will be delivered to your office within 48 – 72 hours after the phone screen approval. Please dispense to your patient with the appropriate dosage instructions.
6. After the initial shipment, please call toll free 1-866-302-5694 to re-order Aloxi™. Re-orders will be processed at the request of the physician only.
7. If the patient's eligibility for the Patient Assistance Program is denied, both you and your patient will receive a letter of explanation.
8. After one year, if your patient continues to need financial assistance, it will be necessary to reapply. A new application must be submitted with the required documentation.

PHYSICIAN INFORMATION (Please print)

Physician Name ______________________ Specialty ______________

Hospital/Clinic Name ______________________ Professional Title ______________

State License No. ______________ Issuing State ________ Expiration Date ______________

DEA No. and exp. date ______________ Tax ID No. ______________

Address ____

City ______________________ State ________ Zip ______________

Phone No. ______________________ Fax No. ______________________

PRESCRIPTION INFORMATION (Please include the physician's State License or DEA number and expiration date)

ALOXI DOSING

_______________ vials of Aloxi™ per Cycle of Chemotherapy Regimen (maximum 1 vial per treatment or 4 vials maximum per month).

If requesting more than one vial per treatment, please provide treatment regimen ______________________________.

Diagnosis: ______________________ ICD-9 Code: ______________

After the initial shipment, please call 1-866-302-5694 to re-order. Re-orders will be processed at the request of the physician only.

Patient's physician to acknowledge and represent thereon that such physician will not distribute or provide product received under the Program to any person other than the intended patient and will not charge such patient for such product.

To the best of my knowledge, this patient does not have any prescription drug coverage (including private insurance, Medicare, Medicaid, county funded assistance, or other public programs) for Aloxi™ .

No claim may be made to any third party payer for payment of product provided under the Program. Product provided under the Program must only be used for the approved patient and may not be sold, traded or returned for credit. The ALOXI Alliance Reimbursement Program requests that physicians do not charge the patient for those professional services associated with this regimen that are not covered by the patient's health insurer.

Please indicate that you agree to these terms by signing below. Failure to comply with these terms may mean you (and any patients you treat) will no longer be eligible to participate in the ALOXI Alliance Reimbursement Program. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature: ______________________ Date: ______________

Can we contact the patient: ☑ **Yes** ☐ **No** (Note: A financial interview is required if applying for Patient Assistance Program)

Reorders will be processed at the request of the physician only, by calling 1-866-30-ALOXI.

Please fax completed application and applicable documentation to 1-866-547-0644.

Enrollment Application - page 2

PATIENT INFORMATION (Please print)

US Resident: ❑ Yes ❑ No SSN/ID No. ____________ Phone No. ____________

Patient Name ____________ Date of Birth ____________

Address ____________

City ____________ State ______ Zip ______

Mailing Address (if different than above) ____________

City ____________ State ______ Zip ______

Employment Status: ❑ Employed ❑ Unemployed ❑ Self-employed ❑ Retired

Gender: ❑ M ❑ F

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Insurance Phone #:	Insurance Phone #:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's SSN:	Policy Holder's SSN:
MD's Provider # (if applicable):	MD's Provider # (if applicable):

FINANCIAL INFORMATION (Only complete if applying for Patient Assistance Program)

A financial interview is required to apply for patient assistance. **For financial interview contact: □ patient or □ physician office.** If the patient qualifies for the Patient Assistance Program during the phone interview, two vials of Aloxi™ will be shipped to the physician's office within 48-72 hours. Documentation verifying the patient's financial situation will be requested during the financial interview and is required in order for patient to continue to receive Aloxi™ after the initial shipment of two vials. Acceptable income documentation includes one or more of the following: 1) most recent tax return, 2) paycheck stub(s), 3) W-2 form(s), or 4) bank statements. Patient or physician office should be prepared to answer the following questions:

Monthly housing cost (mortgage/rent) $ ______ **Liquid Assets (savings, checking, IRA, CDs, etc.)** $ ______

Monthly out-of-pocket prescription cost $ ______ **Household size and Total Gross Annual Income** $ ______

APPLICANT DECLARATION

I certify that the information provided in this form is correct and complete. If needed, MGI PHARMA, Inc. ("the Company") and the ALOXI Alliance Reimbursement Program ("the Program") may request and obtain information about my, or my family's income to enroll me in the Program. I understand that my information will be verified every 6 months and that I will need to reapply to this Program every twelve months.

Permission for Sharing Personal Health Information:

To confirm that I qualify for the Program, my doctor may give a representative of the Program information about my health. My insurer and employer may give the Program information about my insurance. People who work for and with the Company to run the Program may see my health and insurance information and the information on this form, but they may use it only for this Program. The Program will make every effort to keep my information confidential, but if it is accidentally disclosed, federal privacy laws will not protect it.

This permission will last for one year from the time I apply to the Program. If I change my mind before one year has passed, I can call the Program's toll-free phone number and tell them that I have decided to leave the Program. I can also inform my doctor, insurer, or employer in writing that I do not want them to give the Program any more information. I know that this means I may no longer be able to receive assistance from the Program. I also understand that the Company has the right to change or end the Program without prior notification to me.

I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits.

X ____________

Signature of Patient or Patient Representative (if signed by Representative, explain authority to act for the Patient)

Name (print) ____________ Date ____________

Reorders will be processed at the request of the physician only, by calling 1-866-30-ALOXI

Please fax completed application and applicable documentation to 1-866-547-0644.

MD office contact: ____________ **Contact Phone Number:** ____________

Revised March 2005

ALOXI Alliance Reimbursement Program, PO Box 235, San Bruno, CA 94066