

# HEXALEN PATIENT ASSISTANCE ENROLLMENT APPLICATION



## 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 MGI PHARMA Patient Assistance Program please complete the application form.
2. Request that the patient complete page two of the application. Forward the form, along with appropriate income documentation to the address or fax indicated on the form.
3. MGI PHARMA will determine if your patient is eligible.
4. If your patient is eligible to participate in the Program, both you and the patient will receive a letter of acceptance. There will be no charge to your patient.
5. Upon acceptance, the patient's first shipment will be delivered to your office within 7 – 10 days. Please dispense to your patient with the appropriate dosage instructions.
6. After the initial shipment, please call toll-free 1-888-743-5711 to re-order. Re-orders will be processed at the request of the physician only.
7. If the patient's eligibility 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.& Exp. Date \_\_\_\_\_ Tax ID No. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

## PRESCRIPTION INFORMATION

Dosage requesting (refills must be prescribed/requested by physician only):

**PLEASE FILL IN NUMBER OF BOTTLES FOR A 2 MONTH SUPPLY**

Hexalen Dosage 60 Day Quantity

50 mg 100 ct \_\_\_\_\_ number of bottles required for 2 cycles

Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

**After the initial shipment, please call 1-888-743-5711 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 Hexalen.

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.

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 MGI PHARMA Patient Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Reorders will be processed at the request of the physician only, by calling 1-888-743-5711.**

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



**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**

Medicaid:  Yes  No  
Private Insurance:  With prescription benefit  Without prescription benefit  None  
Health Insurance Company \_\_\_\_\_ Provider No. \_\_\_\_\_  
Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

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

Number. of people in household \_\_\_\_\_  
Monthly housing cost(mortgage/rent) \$ \_\_\_\_\_ Liquid Assets (savings, checking, IRA, CDs, etc.) \$ \_\_\_\_\_  
Monthly out-of-pocket prescription cost \$ \_\_\_\_\_ \*Total Annual Household Gross Income \$ \_\_\_\_\_

\*Include the income of all people living with the patient as well as the patient's income, if any. If household income is zero, please attach explanation of patient's means of support.

PLEASE ATTACH A DOCUMENT VERIFYING INCOME (i.e., W-2, tax return, copy of a recent paycheck stub, copy of Social Security check) if applying for Patient Assistance Program. Failure to provide income documentation will render the patient ineligible to participate in the program.

**APPLICANT DECLARATION**

Financial Statement:

I hereby request assistance for the above-mentioned drug manufactured by MGI PHARMA, Inc. I certify that the information provided in this form is correct and complete. If needed, MGI PHARMA, Inc. ("the Company") and the MGI PHARMA Patient Assistance 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. I agree to notify the MGI PHARMA Patient Assistance Program of any changes with regard to my insurance status or selected therapy. I certify that I do not have the ability to pay for my medication.

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 1-888-743-5711**  
Please fax completed application and applicable documentation to 1-866-547-0644.

**MD office contact:** \_\_\_\_\_ **Contact Phone Number:** \_\_\_\_\_