

800.564.0216

Providing Access to Care

Please complete each section to the fullest extent possible. If an item does not apply, please write N/A on that line. **Fax to 866.242.4141.**

Please Check One:

- My patient is uninsured.** He/she has no current insurance and is requesting patient assistance. Complete all sections below.
 My patient has insurance. Complete all sections below **and** attach claims, EOBs, and any other relevant documentation.

SECTION 1 - PHYSICIAN INFORMATION

Physician Name: _____ State License #: _____ DEA #: _____
 Name of Group/Hospital: _____ Tax ID #: _____
 Correspondence Address: _____
 City: _____ State: _____ Zip: _____
 Telephone: (_____) _____ Fax: (_____) _____
 Office Contact Name and Extension: _____
 Shipping Address (if different than above): _____
 City: _____ State: _____ Zip: _____
 ABRAXANE® Dose: _____ Dosing Regimen: _____ Site of Service: _____
 Treatment Start Date: _____ Treatment Completion Date: _____

Physician Certification: I am prescribing ABRAXANE® for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension) (albumin-bound) for this patient based on my professional medical opinion and judgment. I understand that I'm asking for assistance based on my patient's financial need and his/her inability to pay for the ABRAXANE therapy.

Physician Signature: _____ Date: _____
(cannot be a stamped signature)

SECTION 2 - PATIENT INFORMATION

Patient Name: _____ Telephone: (_____) _____
 Correspondence Address: _____
 City: _____ State: _____ Zip: _____
 Social Security #: _____ Date of Birth: _____

SECTION 3 - PATIENT 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 ABRAXANE® for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension) (albumin-bound) been specifically denied?

Yes No If yes, please state the reason: _____

Attach copies of claims, EOBs, and any other relevant documentation.

SECTION 4 - PATIENT FINANCIAL/OTHER INFORMATION

Current annual household gross income	\$
Number of household members dependent on income (include applicant)	
Monthly out-of-pocket medical expenses	\$

Other Information:

- Are you a veteran of the US Armed Forces? Yes No
- Do you permanently reside in the US or a US territory? Yes No
- Do you meet residency criteria for some form of public assistance? Yes No

Medicaid:

- Have you ever applied for 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 the above statements and any information provided are correct and that I understand eligibility under this program is subject to Abraxis™ Oncology's approval. I understand that Abraxis Oncology has reserved the right to modify or terminate this program. **I grant Abraxis Oncology or its agents the right, at all times, to investigate any and all claims made under this program.**

I, _____ (patient), agree to permit my healthcare provider, _____ ("Provider"), to disclose to Abraxis Oncology, the manufacturer of ABRAXANE, such information about me and my medical condition as is reasonable and necessary to:

- Obtain information on insurance coverage and payment for ABRAXANE.
- Determine if I'm eligible to participate in any of the manufacturer-sponsored assistance programs.

I understand that once my health information has been disclosed by my provider, applicable law may no longer protect the information from further disclosure, but that Abraxis Oncology intends to protect the confidentiality of my health information by using it only for the purposes described above.

I understand that I do not have to sign this authorization and that if I choose not to sign it, that will not affect my ability to receive treatment from my healthcare providers or to be enrolled in a health plan or be eligible for health plan benefits. I also understand, however, that unless I sign this authorization, Abraxis Oncology may not be able to verify coverage for ABRAXANE or determine my eligibility for any Abraxis Oncology assistance programs.

I understand that I may withdraw this authorization at any time by providing written notice to my healthcare provider or by calling 800.564.0216 and pressing 3, ARC of Support™ Reimbursement Services. Unless and until I withdraw this authorization, it will remain valid and effective for 1 year. I have read this document or had its contents explained to me, and I freely give my consent as described above. I understand that I will receive a copy of this document once it has been signed below.

Signature of Patient or Legal Representative

Date

Legal Representative's Relationship to Patient

Printed Name of Patient or Legal Representative

The information and services provided by the ARC of Support Reimbursement Services are intended to be advisory in nature only. Neither Abraxis Oncology nor AccessMED (an independent consulting company administering the program) can warrant the accuracy of the information provided or guarantee insurance reimbursement. The healthcare provider and patient remain fully responsible for all claims made to private insurers or government programs, including the accuracy of all information submitted. All claims for Abraxis Oncology products should be made in accordance with legal and contractual requirements. Many factors influence reimbursement, and the policies and practices of private and public payers may change without notice. Abraxis Oncology reserves the right to modify or discontinue the program, without notice, at any time.