



**ENZON COVERAGE ASSISTANCE AND  
PATIENT ACCESS PROGRAM**

**P.O. Box 8013  
Somerville, NJ 08876  
Phone: (800) 345-2252  
Fax: (888) 625-6587**

**Reimbursement Services Instructions:**

- Please complete the application [except for the last section marked "For Patient Assistance Program Only"].
- Please have the patient sign the **Patient Statement Section**.
- **Fax the application to: (888) 625-6587**

**PAP Instructions:**

- Please complete the application in its entirety.
- Please have the Patient sign the **Patient Statement section**.
- Please have the practitioner sign the **Practitioner Statement Section**.
- **Fax the application** with completed therapy information (RX information) for up to a maximum 3-month supply to: **(888) 625-6587**

**Program Eligibility:**

- Patient cannot have or qualify for any prescription coverage for Abelcet, DepoCyt or Oncaspar, including all federal, state and local programs (such as Medicare, Medicaid, TriCare etc).
- Patient must be a legal resident of the United States.
- Patient's total annual household income must be at or below the Enzon Poverty Level (Proof of Income is required – Federal Income Tax Return). See chart below.

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| <u>Household Size</u> | <u>Total Annual Household Income</u> | <u>Total Monthly Household Income</u> | <b><u>Please Note:</u></b><br>While Enzon will make every effort to grant aid when needed, this program is limited to available resources and may be discontinued or revised at any time. |
|-----------------------|--------------------------------------|---------------------------------------|---|
| 1.....                | \$20,800.....                        | \$1,733                               |   |
| 2.....                | \$28,000.....                        | \$2,333                               |   |
| 3.....                | \$35,200.....                        | \$2,933                               |   |
| 4.....                | \$42,400.....                        | \$3,533                               |   |
| 5.....                | \$49,600.....                        | \$4,133                               |   |
| 6+.....               | \$56,800.....                        | \$4,733                               |   |

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**ENZON COVERAGE ASSISTANCE  
AND PATIENT ASSISTANCE PROGRAM**  
Phone: (800) 345-2252 Fax: (888) 625-6587

**Patient Information**

Name of Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) Male Female

Phone Number \_\_\_\_\_ Gender (circle one)

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

1. Does the patient have or qualify for prescription drug coverage in any government program? YES  NO
2. Does the patient have or qualify for prescription drug coverage in any private program? YES  NO
3. Is the patient a legal U.S. resident? YES  NO
4. What is the total **ANNUAL** household income, including social security and pension benefits? \$ \_\_\_\_\_ ANNUAL
5. Household size \_\_\_\_\_

**Insurance Information**  Please check here if requesting Reimbursement Investigation Only [no PAP]

**Primary Insurance**

Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

( )

Phone Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance**

Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

( )

Phone Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**IF REQUESTING PATIENT ASSISTANCE  
PLEASE ATTACH A PRESCRIPTION**

**Therapy Information**

Strength \_\_\_\_\_ Dose \_\_\_\_\_ Sig. \_\_\_\_\_

Quantity \_\_\_\_\_ Length of Therapy \_\_\_\_\_

**Diagnosis Information**

Primary Diagnosis (ICD9 code plus description) \_\_\_\_\_

Secondary Diagnosis (ICD9 code plus description) \_\_\_\_\_

**Facility Contact [who we should call concerning this request]**

Contact Name \_\_\_\_\_

( ) ( )

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Facility and Treatment Information**  **Shipping Address**

Facility Name \_\_\_\_\_ Facility DEA# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( )

Phone Number \_\_\_\_\_ Provider ID# \_\_\_\_\_

Surgery Date \_\_\_\_\_ Discharge Date \_\_\_\_\_

**Patient Statement**

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to Enzon and its agents, all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the Enzon Coverage Assistance and Patient Access Program. I also authorize Enzon and its agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate. I understand that Enzon reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize Enzon to use my Social Security number for identification purposes and record keeping only. I have read, understand and agree to all of the above.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR PATIENT ASSISTANCE PROGRAM ONLY**

**Licensed Prescriber Information**  **Shipping Address**

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address (PRODUCT SHIPMENT PURPOSES) \_\_\_\_\_ Provider ID# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

( ) ( )

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

DEA# \_\_\_\_\_ Professional Designation (MD, DO, etc) \_\_\_\_\_

( )

Office Contact Name \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

**If DEA# is not available, please attach a copy of your state license.**

**Licensed Prescriber Statement**

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Enzon reserves the right to modify or terminate this program at any time. My signature certifies that these goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that Enzon reserves the right to recall the product when necessary.

Licensed Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_