ARC of Support®
ABRAXIS Oncology Resource Center℠

Abraxis Patient Access Program (APAP)
Patient Enrollment Form
800.564.0216, Option3

To request ABRAXANE® for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension) (albumin-bound) patient assistance please complete each section and **fax to ARC of Support® Reimbursement Services at (866) 242-4141.**

This form can also be submitted online. Go to http://www.abraxane.com/professional/reimbursement.aspx Scroll down the page to the APAP Patient Enrollment Form titled *"on-line submission"*.

Please Check One:

☐ My patient is **uninsured**. He/she has no current insurance and requests patient assistance. Complete all sections below.

☐ My patient **is underinsured**. Complete all sections below **and** attach copies of the claims, EOBs and any other relevant documentation.

SECTION 1 - PHYSICIAN INFORMATION

Physician Name	State License#:	DEA #
Name of Group/Hospital	Tax ID #	NPI
Correspondence Address:		
City:	State	Zip
Office Contact Name:	Phone: ( ) -	Extension:
Shipping Address *(if different than above)*		
City:	State	Zip
Treatment Start Date:		

Physician Certification: I am prescribing ABRAXANE® 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 their inability to pay for their ABRAXANE® therapy.

Physician Signature: _____ Date: _____

(can not be a stamped signature)

SECTION 2 - PATIENT INFORMATION

Patient Name:		
Correspondence Address:		
City:	State:	Zip:
Social Security #:	Date of Birth:	Telephone: ( ) -
Diagnosis/ ICD-9CM:	Dosing:	Dosing Schedule:

SECTION 3 – HEALTH INSURANCE INFORMATION

	Medicare	Medicaid	Commercial	Other
Insurance Company Name				
Policy Number				
Group Number				
Telephone Number				
Policy Holder's Name				
Policy Holder's DOB				

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Has coverage for Abraxane been specifically denied? ☐ Yes ☐ No
If yes, please state the reason_____**and fax copies of claims, EOBs and any other relevant documentation.**

SECTION 4 – FINANCIAL/OTHER INFORMATION

Current gross **annual household** income:	$
Number of household members dependent on income (include applicant):	
Monthly out-of-pocket Medical Expenses:	$

Other Information:

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

Medicaid:

- If you do not currently have Medicaid have you ever applied? Yes _____ No _____
- If No, please explain why you have not applied?_____ _____
- If Yes, and your application was rejected, explain reason for rejection?_____

SECTION 5 – AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. **Authorization:** I, Printed Name: _____, SSN: _____, Date of Birth: _____, hereby authorize the above-named medical provider ("Provider") to disclose all protected health information ("PHI") about me, including, but not limited to, records of medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date, to Abraxis BioScience, LLC ("Abraxis"), the manufacturer of ABRAXANE® at 11755 Wilshire Blvd, Suite 2000, 20th Fl, Los Angeles, CA 90025. This Authorization does not include "psychotherapy notes" as defined in the HIPAA Privacy Rule.

2. **Purpose Of The Disclosure:** The purposes of the disclosures authorized herein are to obtain information on insurance coverage and payment for ABRAXANE® (paclitaxel protein-bound particles for injectable suspension) (albumin-bound) for coverage verification, and to determine if I am eligible to participate in any of the manufacturer-sponsored financial assistance programs.

3. **Revocation Rights**: I understand that I do not have to sign this Authorization, and that I have the right to revoke this Authorization at any time by sending a written notice of revocation to Provider, or by contacting ARC of Support® Reimbursement Services at (800) 564-0216 and selecting option 3. I understand that the revocation will become effective upon receipt by the Provider. Any PHI disclosed by the Provider pursuant to this Authorization before the effective date of the revocation is not subject to the revocation. I understand that if I do not choose to sign this Authorization, or if I revoke it, Abraxis may not be able to, or continue to, verify coverage for ABRAXANE® or determine eligibility for any Abraxis assistance programs.

4. **Further Disclosure:** I understand that once the Provider identified above discloses PHI pursuant to this Authorization, the PHI may no longer be protected under federal law, and the recipient of the PHI may further disclose the PHI which it receives pursuant to this Authorization without my consent.

5. **Expiration Date:** I understand that this Authorization will expire one year from the date listed below.

6. **Treatment Not Conditioned on Authorization**. I understand that the Provider listed above will not condition treatment on whether I sign this Authorization.

7. **Right to Copy of Authorization**: I understand that I am entitled to receive a copy of this Authorization.

Patient Signature: _____ **Date:**_____

If completed by the participant's personal representative:[1]

Name of Personal Representative: _____**Signature of Personal Representative:** _____ **Date**:_____

[1]Personal representative must attach either (a) a power of attorney for healthcare purposes notarized by a notary public, or (b) a court order appointing the personal representative to act as the participant's conservator or guardian.

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