PSC PATIENT SUPPORT COORDINATOR®

FAX COMPLETED FORM TO 1-800-822-2496
If you have any questions regarding this form, call 1-800-931-8691

CASE APPLICATION FAX COVER SHEET

TO: (YOUR PSC)	**FROM:**
FAX: 1-800-822-2496	**YOUR FAX:**
PHONE: 1-800-931-8691	**YOUR PHONE:**
RE: (PATIENT'S NAME)	**DATE:**

Fax Checklist:

❑ Physician or Healthcare Provider's signature on white Physician form

❑ Patient or Patient Representative's signature on yellow Patient form

❑ Documentation of Power of Attorney, if applicable

❑ Copy of front and back of insurance card(s)

PSC PATIENT SUPPORT COORDINATOR®

Application Form

FAX COMPLETED FORM TO 1-800-822-2496
If you have any questions regarding this form, call 1-800-931-8691

❑ **NEW**
❑ **RENEWAL**

THIS PAGE TO BE COMPLETED BY PHYSICIAN OR HEALTHCARE PROVIDER

Application Date	Case Number (For Internal Use Only)	❑ Check here for insurance investigation **ONLY**

PLEASE PRINT OR TYPE

PATIENT NAME _____

DIAGNOSIS (ICD-9) INFORMATION: _____

DRUG _____ **DOSAGE** _____

PHYSICIAN NAME	DEA # PROVIDER TAX ID #
CLINIC NAME	NPI #
MAILING ADDRESS	MEDICAID PROVIDER # & PIN
CITY/STATE/ZIP	BC/BS PROVIDER #
CONTACT NAME	CONTACT TITLE
CONTACT PHONE & EXT #	CONTACT FAX #

PATIENT INSURANCE/ASSISTANCE INFORMATION

Does the patient have Medicare coverage: ❑ Yes ❑ No

If **Yes**, check all that apply: ❑ Part A ❑ Part B ❑ Part D ❑ Medicare Advantage

Medicare Policy #		**Effective Date**	

If has PART D, list Prescription Drug Plan information below:

Primary Insurance Company	Phone Number	Policy & Group Number	Policy Holder Name	Policy Holder SSN
Secondary Insurance Company	Phone Number	Policy & Group Number	Policy Holder Name	Policy Holder SSN
VA/State or Other Patient Assistance Coverage	Phone Number	Policy & Group Number	Policy Holder Name	Policy Holder SSN

Medicaid: ❑ Denied/Not Eligible ❑ Not Applied ❑ Pending Coverage

*** Please include copy of insurance cards - front and back ****

I hereby certify as follows: (a) I have obtained from my patient all required authorizations to release his/her information, including financial and medical information to Celgene Corporation and its representatives/agents as needed for this application; (b) I understand that this information will only be used by Celgene and its representatives/agents to assess whether my patient is eligible for the Celgene Patient Support Coordinator program; (c) I have not received, nor will I seek or accept reimbursement for any drug provided to my patient by Celgene; (d) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible for this program, and I will notify Celgene of such change; (e) I understand that I am under no obligation to prescribe any Celgene drug; (f) I have not received and will not receive any benefit from Celgene for prescribing a Celgene drug; (g) the information contained in this form is complete and accurate to the best of my knowledge; (h) if I become aware of any errors in this form, I will notify Celgene of the errors and will do my best to correct those errors.

PHYSICIAN OR HEALTHCARE PROVIDER SIGNATURE _____ **DATE** _____

V.April 2008 application form

PSC PATIENT SUPPORT COORDINATOR®

Application Form

FAX COMPLETED FORM TO 1-800-822-2496
If you have any questions regarding this form, call 1-800-931-8691

❑ **NEW**
❑ **RENEWAL**

PATIENT AUTHORIZATION FORM—TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

This application may be subject to random audit of income and asset information

PATIENT NAME

SEX: ❑ FEMALE ❑ MALE

ADDRESS

MARITAL STATUS: ❑ SINGLE ❑ MARRIED

CITY/STATE/ZIP

BIRTH DATE _____

PHONE #

SS # _____

NUMBER OF PEOPLE LIVING IN HOUSEHOLD _____

Are you a U.S. Armed Service veteran? ❑ Yes ❑ No

TOTAL MONTHLY GROSS FAMILY INCOME:
DO NOT LEAVE BLANK OR INDICATE N/A

$_____ (required)

Including, for example, salary, pension, SS, disability; earnings from dividends; earnings from rental property

TOTAL FAMILY ASSETS:
DO NOT LEAVE BLANK OR INDICATE N/A

$_____ (required)

Including, for example, savings, checking and money market accounts; CDs; estimated market value of IRAs, stocks, bonds, and mutual funds (Do not include household items, personal property, house, car)

To the extent necessary to process and administer my Celgene Patient Support Coordinator application, I hereby:

1. Appoint the Celgene Patient Support Coordinator and its agents as my personal representatives with authority to act on my behalf with respect to decisions related to this application.
2. Authorize the Celgene Patient Support Coordinator and its agents to contact my healthcare providers, health plans, insurers, other potential city, county, state or federal funding sources, social workers and patient advocacy organizations (collectively the "Agencies") on my behalf to request information for my Celgene Patient Support Coordinator application.
3. Direct Agencies to recognize the Celgene Patient Support Coordinator and its agents as my personal representatives for this application.
4. Direct Agencies to release, in electronic or other form, to the Celgene Patient Support Coordinator and its agents such information (including without limitation, relative to my medical condition, treatment or drug therapy) as requested by the Celgene Patient Support Coordinator and its agents for this application.

I understand that the Celgene Patient Support Coordinator and its agents will request only that information needed to process and administer this application, and that they will not disclose the information they obtain, except as needed for this purpose or as required by applicable law.

I hereby certify as follows: (a) the information contained in this application is complete and accurate to the best of my knowledge; (b) I understand that if my prescription drug plan coverage changes or if my financial status changes, I may no longer be eligible for this program, and I will promptly notify the Celgene Patient Support Coordinator of any such changes; (c) If a federal, state or private insurance program decides to reimburse me for the medication requested, I will notify the Celgene Patient Support Coordinator and I understand that I may no longer be eligible for assistance; (d) upon the request of the Celgene Patient Support Coordinator and/or its agents/representatives, I will provide documentation which may include personal financial records in order to verify the information contained in this application; (e) I will notify the Celgene Patient Support Coordinator of any errors contained in this application and will make every effort to correct those errors.

PATIENT or PATIENT REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

PATIENT OR PATIENT REPRESENTATIVE NAME: _____
(PLEASE PRINT)

If signed by Patient Representative, please fax documentation of Power of Attorney.

V.April 2008 application form