MACUGEN® (pegaptanib sodium injection) **Access Program™ (MAP) Enrollment Forms**

MAP helps patients and healthcare providers secure access to and coverage for MACUGEN. MAP offers the following services to patients and physicians:

Reimbursement Counseling: MAP counselors will see if MACUGEN is covered by a patient's insurance provider. If MACUGEN is not covered, other sources of coverage will be investigated for the patient. These may include federal, state, and local assistance programs. MAP counselors can also assist with the prior-authorization process, coding questions, claim denials, and the appeals process. MAP will also work with CarePlus CVS/Pharmacy to determine if access via a specialty pharmacy option is available.

Patient Assistance: Patients will be considered for the patient assistance program if coverage for MACUGEN is not identified through insurance or any other programs, or if coverage is denied.

Patients without insurance coverage may be provided MACUGEN at no cost if they meet preestablished eligibility criteria. These include the following:

1. Completed MAP enrollment form (with patient and physician signatures)
2. Acknowledgement of family income
3. Acknowledgement of US residency

Patients who have insurance but whose plans do not cover MACUGEN, through lack of prescription drug coverage or other reasons, may also be considered for the patient assistance program. To be eligible for assistance through MAP, the patient must meet preestablished eligibility criteria, provide items 1 through 3 above, and follow the steps set forth in items A through D below:

A. Insurance coverage for MACUGEN must be verified by MAP prior to starting treatment with MACUGEN or MAP must be notified no later than 30 days after the first claim denial

B. Prior authorization for MACUGEN must have been obtained if required

C. The patient's physician must ensure appropriate and timely action with the patient's insurance company, including:

   - Filing a claim form with all the necessary information with the applicable insurer

D. Physician must appeal denied claims and must do so in accordance with insurer's and MAP's guidelines

How to Complete the MAP™ Enrollment Forms

Physician Instructions for the MAP Enrollment Form:

- Complete Sections 1-1 through 1-3.
- Carefully read Section 1-4-Physician Certification.
- Sign and date the form.

Physician Instructions for the CarePlus CVS/Pharmacy Enrollment Form:

- Complete all sections, sign and date. The enrollment form will act as an official prescription with a physician signature.
- For Patient Insurance Information Section: Complete this form or attach the patient demographic sheet.

Patient Instructions for the MAP Enrollment Form:

- For Reimbursement Counseling services, complete Sections 2-1 through 2-3.
- For Patient Information Section 2-1, 2-2: complete this form or attach the Patient Demographic sheet.
- For Patient Authorization Section 2-3: a Patient Signature is Required
- For Patient Assistance, complete all sections of the patient enrollment form including Section 2-4: Patient Financial Information.
- You must sign and date the form to receive any services through MAP.

Please return the completed, signed form, along with copies of the insurance card(s), by mail or fax to:

MAP
PO Box 220662
Charlotte, NC 28222-0662
Phone: (866) 272-8838
Fax: (866) 272-8839

Patient Enrollment Form - MACUGEN® (pegaptanib sodium injection) **Access Program™ (MAP)**

Please fill out each section. If an item does not apply, please write "N/A."
Please mail or fax the completed application to:

MAP
PO Box 220662, Charlotte, NC 28222-0662
Phone: (866) 272-8838 Fax: (866) 272-8839

Faxed enrollment forms are acceptable

Section 2-1- Patient Information (complete in lieu of a Patient Demographic sheet)

Patient Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____
City: _____ State: _____ ZIP Code: _____
Daytime Phone: (____) _____ Evening Phone: (____) _____

___ I am a legal US resident

Section 2-2- Patient Health Insurance Information (complete in lieu of a Patient Demographic sheet)

Do you have insurance? ___YES ___ NO (If yes, complete the table below. Include all insurance policies.)

Have you ever applied for Medicaid or other public assistance programs? ___ YES ___ NO
If yes, please specify: _____

Result of application: ___ Approved ___ Pending ___ Denied, reason for denial:_____

	Medicare	Medicaid	Commercial/Secondary/Other
Insurance company name	_____	_____	_____
Policy number	_____	_____	_____
Group number	_____	_____	_____
Telephone number	_____	_____	_____
Policyholder's name	_____	_____	_____
Policyholder's date of birth	_____	_____	_____

Section 2-3 – Patient Authorization (Required)

I authorize my healthcare providers and health plans to disclose personal and medical information about me to Eyetech Inc. and its agents and contractors ("Eyetech Inc.") to: (1) establish my eligibility for benefits through the Macugen Access Program™; (2) communicate with my health care providers and me about my medical care; and (3) provide Macugen® (pegaptanib sodium injection) support services including facilitating the provision of Macugen to me. I understand that once my health information has been disclosed to Eyetech Inc., federal privacy laws may no longer restrict its further disclosure. Eyetech Inc. agrees to use and disclose this information only for the above purposes and as permitted by law.

I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Eyetech Inc. in writing and submitting the cancellation by fax to: 1-000-000-0000. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient Signature: _____ Date: _____

Physician Enrollment Form - MACUGEN® (pegaptanib sodium injection) **Access Program™ (MAP)**

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A."

Please mail or fax the completed application to:

MAP
PO Box 220662, Charlotte, NC 28222-0662
Phone: (866) 272-8838 Fax: (866) 272-8839

Section 1-1 – Physician Information

Physician Name: _____ State License Number: _____

Site/Facility Name: _____ Contact Name: _____

Facility Address: _____ City: _____ State Zip: _____

Phone Number: _____ Fax Number: _____

Tax ID Number: _____ Payer Specific Provider Number : _____

Section 1-2 – Delivery Information (please indicate shipping address if different from above)

PLEASE ONLY COMPLETE SECTION 2-2 FOR CONSIDERATION FOR THE PATIENT ASSISTANCE PROGRAM

Site/Facility Name: _____ Contact Name: _____
Facility Address: _____ City: _____
Phone Number: (____) _____ Fax Number: (____) _____

Section 1-3 – Prescribing Information

Patient Diagnosis (please provide code [s]) : _____
Other Pertinent Medical Information : _____

As part of your patient's eligibility in the patient assistance program, you will be asked to periodically verify continued use of MACUGEN.

Section 1-4 – Physician Certification

I verify and attest that the information provided is current, and accurate to the best of my knowledge. I certify that MACUGEN is medically necessary for this patient and I will be supervising the patient's treatments. I certify that I have obtained from my patient all required authorization for the release to Eyetech Inc. and their agents and representatives of my patient's identification and insurance information. I understand that any information provided is for the sole use of Eyetech Inc. and their agents and representatives to verify my patient's insurance coverage to assess, if applicable, patient's eligibility for participation in the patient assistance program and to otherwise administer MAP. I understand that application to the patient assistance program does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, the patient may no longer be eligible for the patient assistance program, and I agree to immediately notify MAP representative if I become aware of changes in the patient's insurance status. I certify that I will not accept payment from patients (or any third party), in whole or in part, for MACUGEN obtained through the patient assistance program. I certify that I will not request MACUGEN through patient assistance program for which I received reimbursement. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for MACUGEN supplied at no charge to me or my patient through MAP's patient assistance program, I will immediately notify a MAP representative, and I understand that in such event Eyetech Inc. will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe MACUGEN and that I have not received nor will I receive any benefit from Eyetech Inc. or their agents or representatives for prescribing MACUGEN.

Physician Signature: _____ Date: _____

FILL OUT SECTION 2-4 ONLY IF YOU WANT TO APPLY FOR THE PATIENT ASSISTANCE PROGRAM

Section 2-4 – Patient Financial Information

Total number in household (applicant and dependents): _____

Please list total gross annual household income for each item listed below. Include all income of persons living in the household:

Salary/Wages	$_____	Supplemental Social Security Income	$_____
Pensions	$_____	Social Security Disability Income	$_____
Alimony/Child Support	$_____	Other	$_____
Social Security Retirement Income	$_____	Total Annual Income	$_____

I _____ (patient's name), certify that the above information of my previous years income is accurate to the best of my knowledge. I also agree to provide my W-2, 1040, or Social Security Benefit statement, if requested at a later date.