

For Internal Use Only

Case #:

Date:

☐ RS ☐ PAP

Comprehensive Oncology Reimbursement Expertise (CORE) ENROLLMENT FORM

P.O. Box 7588 ♦ Overland Park, KS 66207
Phone: 888-587-3263 ♦ Fax: 866-676-4073
Between the hours of 9 AM and 8 PM (ET)

PATIENT INFORMATION: (Please type or print clearly)

Patient Name (First MI Last): _____

Social Security #: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Contact Name (if other than patient): _____ Contact Phone: _____

Permanent U.S. Resident? ☐ YES ☐ NO Gender: ☐ Male ☐ Female

FINANCIAL INFORMATION: (Please complete with a dollar amount. Please do NOT leave blank or put N/A.)

Annual Gross Household Income (Before Taxes): # of household members dependent on income stated:

Attach copies of proof of income for you and all dependent persons in the household.

To include you, your spouse and dependents

Example: Federal income tax (form 1040, 1040EZ, 1099, 1099-DIV, or 1099-I) or yearly benefits statement (SSA, 1099, or award).

INSURANCE INFORMATION: (Please list all policies and provide copies of cards, front and back.)

**** PLEASE INCLUDE COPY OF INSURANCE CARDS, FRONT AND BACK AND ENLARGED ****

Does the patient have Medicare Coverage: ☐ YES ☐ NO Check all that apply: ☐ Part A ☐ Part B
☐ Part D ☐ Medicare Advantage

Medicare Policy #:

Effective Date:

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

	Insurance Name:	Phone #:	ID / Policy #:	Group #:
Primary:				
Secondary:				
State Program:				
Veteran or Other Plan:				

MEDICAID: ☐ Not applied ☐ Denied ☐ Pending VETERAN? ☐ YES ☐ NO Applied for VA? ☐ YES ☐ NO

I verify that the information provided in this application is current, complete, and accurate. I understand that any assistance provided to me by Teva Pharmaceuticals ("Teva") through the Comprehensive Oncology Reimbursement Expertise (CORE) Program is contingent upon my ability to meet the eligibility criteria and that completing the enrollment process does not guarantee acceptance into the CORE Program. I also understand that Teva reserves the right at any time and without notice to modify the application form or modify or discontinue this Program and the related eligibility criteria. I authorize Teva to use my Social Security number for identification purposes and record keeping. I agree to notify the CORE Program within thirty (30) days if there is any change in the status of my eligibility to receive products through this Program. I certify that I have not received, and will not seek to receive, reimbursement for the Teva drug requested and/or supplied under the CORE Program. I have read, understand and agree to all of the above. Unless revoked by me in writing, this authorization will be effective until I terminate my participation in the CORE Program in writing sent to the address above.

Patient/Legal Guardian* Signature: _____ Date: _____

* Please provide a description of the Legal Guardian's authority to act for the patient.

I authorize my healthcare providers and insurance companies to disclose to Teva Pharmaceuticals ("Teva") and its agents and assignees, all medical records and information, financial and insurance records and information, as well as other personal identifying information, with respect to myself, for the purpose of my enrollment or participation in the Comprehensive Oncology Reimbursement Expertise (CORE) Program. Although Teva will safeguard my information and only use it for the intended purposes, I understand this information may be subject to re-disclosure and no longer protected by federal privacy rules. My right to treatment, payment for treatment, or insurance enrollment, eligibility for insurance benefits is not conditioned on me signing this authorization. I may revoke this authorization at any time, except to the extent action may have already been taken based on this authorization, by sending notice in writing to P.O. Box 7588, Overland Park, KS 66207, Attn: Chief Privacy Officer. Unless revoked, this authorization will remain in effect until I terminate my participation in the CORE Program.

Patient/Legal Guardian* Signature: _____ Date: _____

* Please provide a description of the Legal Guardian's authority to act for the patient

Please Fax Completed Form to 866-676-4073

For Internal Use Only	Case #:	Date:	<input type="checkbox"/> RS <input type="checkbox"/> PAP
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PHYSICIAN INFORMATION: (Please type or print clearly)

Physician Name: _____ DEA #: _____

NPI #: _____ Medical License #: _____ MD Tax ID #: _____

Facility Name: _____ GroupTax ID #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Medicaid Provider # and Pin: _____ PTAN#: _____

Clinical Contact: _____ Contact Title: _____

Contact Phone: _____ Ext: _____ Contact Fax: _____

Billing Contact: _____ Contact Title: _____

Contact Phone: _____ Ext: _____ Contact Fax: _____

PRESCRIBING INFORMATION:

Patient Name (First MI Last):			Date of Birth:		
Site of Care:			Is patient being treated outpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient Primary Diagnosis – ICD-10 Code:			Description:		
Patient Secondary Diagnosis – ICD-10 Code:			Description:		
Clinical History/Failed Therapies:					
Choose Drug Name:					
<input type="checkbox"/> BENDEKA™ (bendamustine hydrochloride) Injection <input type="checkbox"/> TREANDA® (bendamustine hydrochloride) Injection <input type="checkbox"/> TRISENOX® (arsenic trioxide) injection <input type="checkbox"/> SYNRIPO® (omacetaxine mepesuccinate) for Injection, for subcutaneous use <input type="checkbox"/> GRANIX® (tbo-filgrastim) Injection					
Therapy GIVEN:			Therapy PLANNED for month:		
Date(s):	Dose:	Frequency:	Date(s):	Dose:	Frequency:

DISTRIBUTION:

If shipping address is the same as the mailing address above, please confirm by checking the box. If not, please indicate shipping address below.

☐ Shipping Address Is Same As Mailing Address

Shipping Address: _____

City: _____ State: _____ Zip: _____

On behalf of my patient, I request assistance for the oncology drug manufactured by Teva Pharmaceuticals ("Teva") specified in this application. I attest that the information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed the drug specified in this application based on my professional judgment of medical necessity. I understand that the patient must meet financial parameters to be eligible under the program. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested, replaced and/or supplied under the Comprehensive Oncology Reimbursement Expertise (CORE) Program. I certify that no free product provided under this Program will be distributed for sale to any individual or organization or returned for credit. I understand that if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Teva will bill me for the covered product, and I agree to be responsible for payment of the bill. If I submit a claim to patient's insurance company for services rendered in conjunction with the administration of a product provided under this program, I agree to fully disclose to the insurance company that the product was provided free of charge under this Program. I agree to abide by this certification throughout any participation in the Program and to notify a Program representative if aspects of my certification are no longer applicable. I understand that if the patient's income or insurance status changes, the patient may no longer be eligible under this Program. I agree to immediately notify a Program representative if I become aware that the patient's insurance or income status changes, or if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge. I understand that Teva reserves the right to modify or terminate this Program at any time without prior notice and reserves the right to recall the product when necessary. I understand that I am under no obligation to prescribe any Teva drug to participate in this Program and that I have not received, nor will I receive any benefit from Teva or its agents, for prescribing a Teva drug. I understand that Teva and its agents are not responsible for filing any insurance claim. PAP: I understand that in a number of circumstances, as described in CORE Program supporting material, I will be required to appeal the denial from patient's insurance company before receiving any product under this program. I agree to become familiar with these requirements and certify that in circumstances where an appeal is required: (i) I will submit a claim to the patient's insurance company; and (ii) if the claim is denied I will submit an appeal to the patient's insurance company, prior to requesting free product under this Program. If product is provided by Teva under this Program, I will return to patient any deductibles or co-insurance made by patient for the product.

Physician Signature: _____ Date: _____

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