

CELGENE THERAPY ASSISTANCE PROGRAM NEW CASE APPLICATION FORM

FAX COMPLETED FORM TO 800-822-2496

If you have questions regarding this form, call 888-423-5436 (888-4-CELGENE), select Option #3

Application Date	Case Number	<input type="checkbox"/> Check Here for Insurance Investigation only:
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THIS SECTION TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER

PLEASE PRINT OR TYPE

DIAGNOSIS INFORMATION: _____ Thalomid Dosage _____

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

Patient Name _____

PATIENT INSURANCE /ASSISTANCE INFORMATION

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

Primary Insurance Company Name	Claim Address Phone Number	Policy Number Group Number	Policy Holder Name	Policy Holder DOB	Patients Relationship to Policy Holder	Policy Holder Social Security Number
Secondary Insurance Company	Phone Number	Policy & Group Number	Policy Holder Name	Policy Holder DOB	Patient's Relationship to Policy Holder	Policy Holder Social Security Number
VA/Other Patient Assistance Coverage	Phone Number	Policy & Group Number	Policy Holder Name	Policy Holder DOB	Patient's Relationship to Policy Holder	Policy Holder Social Security Number

I hereby represent, covenant and certify as follows: (a) I have obtained from my patient all required authorization to release to Celgene and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information. (b) I understand that this information is for the sole use of Celgene and its representatives/agents to assess the patient's eligibility for participation in the Celgene Patient Assistance Program. (c) I have not received, nor will I seek or accept reimbursement for any drug provided for my patient in the Celgene Patient Assistance Program. (d) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program, and I will notify the Celgene Patient Assistance Program if I become aware of any such changes. (e) I understand that I am under no obligation to prescribe any Celgene drug and I have not received and will not receive any benefit from Celgene for prescribing a Celgene drug. (f) The information contained in this form is complete and accurate to the best of my knowledge. (g) I will notify the Celgene Patient Assistance Program of any noncompliance with the foregoing.

PHYSICIAN OR HEALTH CARE PROVIDER SIGNATURE _____ DATE _____

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THIS SECTION TO BE COMPLETED BY PATIENT OR GUARDIAN

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

PATIENT'S NAME _____

SEX: FEMALE MALE

ADDRESS _____

MARITAL STATUS: SINGLE MARRIED

CITY _____ STATE _____ ZIP CODE _____

BIRTH DATE _____

PHONE NUMBER _____

SS # _____

NUMBER OF PEOPLE LIVING IN HOUSEHOLD _____

***Please provide a copy of your most recent W-2 or Income Statement.**

**Average Monthly Gross
Family Income:**
\$ _____

Average Monthly Cost of Thalomid®:
\$ _____

Total Family Assets: \$ _____

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

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)***

I hereby represent, covenant and 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 under this program, and I will promptly notify the Celgene Patient Assistance Program of any such changes. (c) In the event that I become eligible for a benefit through a Federal, State or Private program which may reimburse for the medication requested I will notify the Celgene Patient Assistance Program and understand that I may no longer be eligible for assistance. (d) Upon the request of Celgene and/or its agents/representatives I will provide documentation, including but not limited to personal financial records, to verify the information contained in this application. (e) I will notify the Celgene Patient Assistance Program of any noncompliance with the foregoing.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

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PATIENT AUTHORIZATION FORM – TO BE COMPLETED BY PATIENT OR GUARDIAN
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To the extent necessary to process and administer my Celgene Therapy Assistance Program application, I hereby:

1. Appoint Celgene and its agents as my personal representatives with authority to act on my behalf with respect to decisions related to this application;
2. Authorize Celgene and its agents to contact my health care 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 Therapy Assistance Program application;
3. Direct Agencies to recognize Celgene and its agents as my personal representatives for this application; and
4. Direct Agencies to release, in electronic or other form, to Celgene and its agents such information (including without limitation, relative to my medical condition, treatment or drug therapy) as requested by Celgene and its agents for this application.

I understand that Celgene 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.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

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