RETAVASE® (reteplase) SOLUTIONS™ PATIENT ASSISTANCE PROGRAM

The following information is required to enable the Patient Assistance Program counselors to determine eligibility for product replacement. Completed application with signature must be faxed or mailed to the following address before product can be shipped.

Mail: **RETAVASE Solutions Program**
PO Box 220807
Charlotte, NC 28222-0807

Telephone: (866) RETAVAS or (866) 738-2827

Fax: (866) 279-0712

PATIENT INFORMATION (Please Print Clearly)

Patient Name: ____________________

Date of Birth: ____________ ☐ Male ☐ Female

Street Address: ____________________

City, State Zip: ____________________

Phone Number: (____)____________________

Social Security Number: ____________________

HEALTH INSURANCE INFORMATION

Does the patient have medical insurance (including Medicaid or Medicare)? ☐ YES ☐ NO

If NO, has the patient applied for Medicaid?
☐ YES ☐ NO
If patient has applied for Medicaid, is the application:
☐ Denied ☐ Pending, Date Submitted: ________

Primary Insurance Information

Insurance Company: ____________________
Telephone: (____)____________________
Policy ID Number: ____________________
Group ID Number: ____________________
Subscriber Name: ____________________
Relation to Patient: __________ Date of Birth: ________

Secondary Insurance Information (if applicable)

Health Insurance Company: ____________________
Telephone: (____)____________________
Policy Number: __________ Group Number: ________
Subscriber Name: ____________________
Relation to Patient: __________ Date of Birth: ________

If a third-party payer has denied the claim, please submit the Explanation of Benefits (EOB) with application.

FINANCIAL INFORMATION

Gross Annual Household Income: ____________________

☐ Income Verification in Patient File

Reported financial information may be verified by an audit as deemed necessary by the program.

THERAPY INFORMATION *(Documentation Required)*

Number of RETAVASE Vials Administered: ____________
Date of Administration: ____________________

Documentation is required and may include one or more of the following:

☐ Administration Record and Pharmacy Dispensing Record
☐ Discharge Summary
☐ Itemized Billing
☐ Other____________________

FACILITY INFORMATION

Treating Physician Name: ____________________

State License Number: ____________________

Facility Name: ____________________

Street Address: ____________________

City, State Zip: ____________________

Contact Name: ____________________

Telephone: (____)________ Fax:(____)____________

Shipping Address (if different than address listed above):

Facility Name: ____________________

Street Address: ____________________

City, State Zip: ____________________

Telephone: (____)________ *Fax:*(____)____________

AUTHORIZATION

We certify that we have obtained appropriate patient consent to release the information provided in this application. The information is being obtained for the sole purpose of receiving replacement product for the prescribed treatment. In addition to releasing information to the program, we consent to verification by audit of reported information as deemed necessary. We confirm that RETAVASE was provided free of charge to persons who are ill and do not have resources to obtain medical treatment. We agree to retain a copy of this form in the hospital's record and to make it available to the Internal Revenue Service upon request.

Authorized Signature: ____________________

Title: ____________________

Date: ____________________

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RETAVASE® (reteplase) SOLUTIONS™ PROGRAM
INCOME VERIFICATION SHEET FOR PATIENT ASSISTANCE REQUEST

The RETAVASE Solutions Program encourages you to retain a copy of the application with this form for the facility's record and to make it available to the Internal Revenue Service upon request.

PATIENT INFORMATION

Patient Name: ______________________________ ☐ Male ☐ Female

Street Address: ______________________________ City, State Zip: ______________________________

Social Security Number: ______________________________ Date of Birth: ______________________________

FINANCIAL INFORMATION

Gross Annual Household Income: ______________________________

Source of Patient Financial Information:

☐ Patient/Self Reported

☐ Reported by Family Member

☐ Reported by Guardian or Caregiver

☐ Documented on Tax Return

☐ Documented on W-2 or Paystub

☐ No Visible Income, Assets. No known residence.

THERAPY INFORMATION

Number of RETAVASE Vials Administered: ______________ Date of Administration: ______________________________

FACILITY INFORMATION

Treating Physician Name: ______________________________ State License Number: ______________

Facility Name: ______________________________

Street Address: ______________________________ City, State Zip: ______________________________

Contact Name: ______________ Telephone: (_____)______________ Fax: (_____)______________

Shipping Address (if different than address listed above):

Facility Name: ______________________________

Street Address: ______________________________ *City, State Zip:* ______________________________

Telephone: (_____)______________ *Fax: (_____)______________*

AUTHORIZATION

We certify that we have obtained appropriate patient consent to release the information provided in this application. The information is being obtained for the sole purpose of receiving replacement product for the prescribed treatment. In addition to releasing information to the program, we consent to verification by audit of reported information as deemed necessary. We confirm that RETAVASE was provided free of charge to persons who are ill and do not have resources to obtain medical treatment. We agree to retain a copy of this form in the hospital's record and to make it available to the Internal Revenue Service upon request.

Authorized Signature: ______________________________ Date: ______________________

Title: ______________________________