SICOR Pharmaceuticals, Inc.
Customer Sales Support
1-800-729-9991

PATIENT ELIGIBILITY APPLICATION FORM
The following information is required to enable the Patient Assistance Program Specialists to determine eligibility for a patient. If eligibility is established, the completed **original form** with signature must be faxed back to:

SICOR Oncology Patient Assistance Program
ATT: Customer Sales Support
FX: 949-859-5682

New Application ☐ Re-application ☐

Section 1- To be completed by patient or patient's family and submitted to physician.

Patient Information (Please Print Clearly)

Name of Patient

Name of Guardian (if appropriate)

Patient's Address

City State Zip

( ) ( )
Phone # Home Work

Date of Birth SS#

M ____ F____

U.S. Citizen? Yes____ No____

Insurance Information

Name of Insurance Co. Policy Number

Group Number

( )
Phone #

Contact Person

Subscriber's Name

Date of Birth

Subscriber's Relationship to Patient

Secondary Insurance Name of Company

Policy # Group #

( )
Phone # Contact Person

Has patient or guardian applied to public programs such as Medicaid or state drug assistance program?
Y___ N___
Has coverage been denied for this product?
Y___ N___
If yes, program(s) applied to _____

FINANCIAL INFORMATION

Gross Annual Household Income & Source of Income:

Salary/Wages/Unemployment
$_____
SSI
$_____
SSDI
$_____
Other: $_____
$_____
Total $_____

Number of household members dependent on income stated above (include applicant) _____

PLEASE CHECK WHERE APPLICABLE

- Attached is a copy of my most recent federal tax return. _____
- I do not file federal taxes. _____

Application Declaration

"I promise that the information on this form is correct and complete. If needed, SICOR Pharmaceuticals, Inc., and its Patient Assistance Program (the "Program") may request and obtain information about my, or my family's income to enroll me in the Program. I understand that the Program administrators reserve the right any time and without notice to modify the application form; modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time."

Receipt of product will be based on availability. Requests on backordered products will be cancelled. SICOR will not be responsible for any monetary reimbursement, or product replacement in the event product is unavailable.

Please indicate your agreement to these terms by signing below. Signature of Patient or Patient Representative (if signed by Representative, explain authority to act for the Patient.)

Patient Signature Date

Section 2- To be completed by physician

Prescribing Information

Product Name

Dose per treatment

# of treatments

Name of Physician

Address for direct shipment

City State Zip

( ) ( )
Phone # Fax#

Physician's DEA # State License #

Office Contact Name

Patient Diagnosis

Expected Duration of Therapy (months)

PRODUCT DISTRIBUTION INFORMATION
Indicate special shipping instructions (e.g.office hours available for delivery etc)

To the best of my knowledge, this patient does not have prescription drug coverage (including Medicaid, county funded assistance, or other public programs) for these requested products.

The SICOR Oncology Patient Assistance Program requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. The insurance company may be billed for services. No claim, however, may be made to any third party payer for payment for product provided under the program. **Products offered under this program may not be sold, traded or returned for credit. Unused products must be returned to SICOR.** Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's requested product.

Physician Signature Date

MUST FAX A COPY OF YOUR PHYSICIAN'S STATE LISCENCE

Request will NOT be processed without a copy of physician's state license