For Internal Use Only	Case #:		Date:		❑ RS ❑ PAP ❑ PRP

Cephalon Oncology Reimbursement Expertise (CORE) ENROLLMENT FORM

6900 College Boulevard, Suite 1000 ◆ Overland Park, KS 66211
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:** ______________

US Citizen/Legal 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): ______________________

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

# of household members dependent on income stated: ______________________

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 authorize my healthcare providers, insurance companies, employers, and other sources as deemed necessary to disclose to Cephalon, Inc. (Cephalon) 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 Cephalon Oncology Reimbursement Expertise (CORE) Program. I also authorize Cephalon and its agents or assignees to disclose all such records and information, whether provided by myself or any third party, for the purpose of my enrollment or participation in the CORE Program. I understand that any such records or information that reveals my identity will not be used for any purpose other than that described above unless I have given written consent. I understand that any assistance provided to me by Cephalon through the 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 Cephalon 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 Cephalon 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 Cephalon drug requested and/or supplied under the CORE Program. I have read, understand and agree to all of the above. This consent is valid until rescinded in writing and a photocopy or faxed copy may be used in place of the original.

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

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Cephalon Oncology Reimbursement Expertise (CORE)
ENROLLMENT FORM

6900 College Boulevard, Suite 1000 ◆ Overland Park, KS 66211
Phone: 888-587-3263 ◆ Fax: 866-676-4073
Between the hours of 9 AM and 8 PM (ET)

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: ____________________ **BCBS Provider #:** ____________________

Clinical Contact: ____________________________ **Contact Title:** ____________________

Contact Phone: ____________________ **Ext:** ______ **Contact Fax:**

Billing Contact: ____________________________ **Contact Title:** ____________________

Contact Phone: ____________________ **Ext:** ______ **Contact Fax:** ____________________

PRESCRIBING INFORMATION:

Patient Primary Diagnosis – ICD-9 Code:	**Description:**
Patient Secondary Diagnosis – ICD-9 Code:	**Description:**
Clinical History/Failed Therapies:	
Choose Drug Name: ☐ **TREANDA® (bendamustine HCl) for injection**	☐ **TRISENOX® (arsenic trioxide) 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 Cephalon, Inc. (Cephalon) drug 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 Cephalon 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, Cephalon will bill you 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 Cephalon 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 Cephalon drug to participate in this Program and that I have not received, nor will I receive any benefit from Cephalon or its agents, for prescribing a Cephalon drug. I understand that Cephalon 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 Cephalon under this Program, I will return to patient any deductibles or co-insurance made by patient for the product. PRP: I understand and certify that: (i) I have performed insurance verification by providing sufficient detail to meet the insurance company's benefit verification requirements and the patient's insurance will cover the product as specifically prescribed by me (including, if applicable, the patient's medical condition that is being treated and dosing regimen); (ii) I will submit a claim to the patient's insurance company; (iii) if the claim is denied I will submit an appeal to the patient's insurance company; and (iv) in the event that patient's insurance company ultimately denies the claim and replacement product is provided by Cephalon 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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For full prescribing information for Treanda, go to www.treanda.com. For full prescribing information for Trisenox, including BOXED WARNING, go to www.trisenox.[illegible].