

Thank you for your interest in applying to the ENCourage Foundation®. The Foundation is a non-profit program that helps needy patients obtain Enbrel®.

To apply for the Foundation:

- 1. Read and fill out the enclosed application (Form B)**
- 2. Sign and date the application (Form B – Patient Certification and Consent)**
- 3. Provide proof of income. You may submit any one of the following:**
 - latest federal or state tax return,
 - latest W-2 statement,
 - SSDI/SSI award letter,
 - bank statements (last 3 months showing income deposits),
 - pay stubs (last 2 pay stubs), **or**
 - state program acceptance letter or card (e.g. ORSA).**If you do not have proof of income, you may complete one of the following forms:**
 - notarized income statement (form enclosed), **or**
 - attestation statement with two signatures (form enclosed).
- 4. Have your physician complete the Physician Portion of the application (Form A)**
- 5. Mail (in the envelope provided) or physician office staff may fax the completed application (Patient Enrollment Form [Form B], Physician Form [Form A], and proper income documentation) to:**

**ENCourage Foundation®
PO Box 4133
Gaithersburg, MD 20879-7808
Fax: 888/508-8083**

Faxed copies of applications are accepted, but must be sent from the physician's office. Once we receive a complete application, both you and your physician will be notified of your eligibility. For any questions please call 800/282-7752, Monday through Friday, 8am to 8pm Eastern Time.

Sincerely,
ENCourage Foundation®



FORM B: PATIENT ENROLLMENT FORM

Patient Information

Patient's Name: _____

Social Security Number: _____ Date of Birth: _____ Sex: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Patient Email: _____

Foundation ID# :]

Distributor ID# :]

Physician Information

Physician Name: _____

Physician Contact Person (other than physician): _____

Facility/Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ FAX: _____

Physician Email _____ Physician Contact Email _____

Insurance Information (Please complete one of the boxes below to describe your health insurance)

- () I do have insurance (whether it covers Enbrel or not) *(please fill out the insurance coverage section)*
- () I do not have insurance and I am not eligible for any public health insurance

<p>Insurance Coverage <i>(Ex: Blue Shield of CA, AARP, VA/DOD, Indian Health Service, Discount Card Program)</i></p> <p>Primary Insurance Name: _____ Policy Holder Name: _____</p> <p>Supplemental Insurance Name: _____ Policy Holder Name: _____</p> <p>Secondary Insurance Name: _____ Policy Holder Name: _____</p>	<p>Medicare (A, B, and/or D) Effective Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/> N/A Telephone: () _____</p> <p>Medicaid Effective Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/> Emergency <input type="checkbox"/> N/A Telephone: () _____</p>
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Financial Information

Household Income: \$ _____ Source of Income: _____ Number of people in your household: _____



PATIENT CERTIFICATION AND CONSENT

Patient's Name: _____

- I would like to receive Enbrel® (etanercept) free of charge from the ENCOURAGE FOUNDATION®. I do not have, nor am I eligible for, any private or public health insurance other than that listed above. I do not have, nor am I eligible for, any other form of public assistance with my medical expenses.
- I certify that if I will not request reimbursement from any insurance carrier or government health benefit program for any Enbrel® I receive from the ENCOURAGE FOUNDATION®.
- I certify that the enclosed information is correct to the best of my knowledge. I understand that this information will not be used for any other purpose unless I give written consent, the government requires it, or the ENCOURAGE FOUNDATION® removes my name and any other identifying information.
- I understand that the ENCOURAGE FOUNDATION® may change or stop this program with respect to any patient, or in its entirety, at any time. I also understand that, although Enbrel® may be given to me free of charge now, this does not mean I will be entitled to receive it free of charge indefinitely.
- I will not sell, trade, or distribute Enbrel® given to me by the ENCOURAGE FOUNDATION®.
- I authorize my health care provider and my health plan(s) to provide my medical records and related information, including but not limited to my name, Social Security number, address, and date of birth, and financial information to the ENCOURAGE FOUNDATION®, Amgen and Wyeth, the marketers of Enbrel, their agents, and designees, so that they can obtain information about my insurance coverage and determine if I am eligible to receive ENBREL® at no cost to me through the ENCOURAGE FOUNDATION®. I also authorize the Foundation, Amgen its agents, and designees, to share my medical and other related information with each other and with my health care providers and health plan(s) for the purpose of facilitating my ability to receive ENBREL® through the Foundation.
- Once my health information has been disclosed by my Provider and my health insurers, federal privacy laws may no longer protect the information from further disclosure. However, the ENCOURAGE FOUNDATION®, Amgen, and Wyeth agree to protect my information by using and disclosing it only for the purposes described above or as required by law. I understand that I do not have to sign this Authorization, but if I do not, I may have to pay for Enbrel myself. My health care providers and health plans will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this Authorization. I may revoke this Authorization at any time by mailing or faxing signed letters of revocation to the ENCOURAGE FOUNDATION® at P.O. Box 4133, Gaithersburg, MD 20879-7808 or via fax at 888/ 508-8083. I am entitled to a copy of this Authorization. This Authorization expires ten (10) years from the date of my signature. A photocopy of this authorization will be as valid as the original.
- I understand that the ENCOURAGE FOUNDATION®, Amgen, Wyeth, or its agents or designees, may need to work with my social worker or other health care professional to case manage and coordinate care, including drug refills, on my behalf. I hereby grant authority to _____ (first/last name), _____ (relationship to patient) to act as my representative for the purpose of coordination of therapy in the ENCOURAGE FOUNDATION®.

Patient Signature

Date

The ENCOURAGE FOUNDATION® reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. The ENCOURAGE FOUNDATION® also reserves the right to make an independent determination of financial and medical need.

ENCOURAGE FOUNDATION®
P.O. Box 4133
Gaithersburg, MD 20878-7808
Phone: 800/282-7752 Fax: 888/508-8083



Form A: PHYSICIAN FORM/PROVIDER PRESCRIPTION FORM

Physician Instructions: Please complete form and fax or mail the completed application packet (Form A, Form B, and income documentation) to the address below.

To: ENCOURAGE FOUNDATION®
PO BOX 4133
GAITHERSBURG MD 20879-7808
Phone: 800/282-7752 Fax: 888/508-8083

From: Physician Name: _____ DEA#: *(Optional)* _____
State License Number: ***(Required)*** _____
Physician Contact (other than physician): _____
Facility/Practice Name: _____
Address (no PO boxes please): _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ FAX: _____
Physician Email _____ Physician Contact Email _____

Patient Information

Patient's Name: _____ Case number: _____
Social Security Number: _____ Date of Birth: _____ Sex: _____
Patient ID: _____ Patient Dx: _____
Phone (Home): _____ Phone (Work): _____ Phone (Mobile): _____
Address: _____
City: _____ State: _____ Zip Code: _____

Prescribing information for ENBREL® (etanercept)

Dosage

Medication	Dose	Frequency	Check One	Quantity
ENBREL® (etanercept)	50mg Prefilled Syringe	1x/week		New Enrollees - One year supply - Shipments Monthly for the first 4 months, every two months for the remaining 8 months. Re-enrollees - One year supply - Shipments Every two months
ENBREL® (etanercept)	50mg SureClick	1x/week		
ENBREL® (etanercept)	25mg Vial	2x/week		
ENBREL® (etanercept)	25mg Prefilled Syringe	2x/week		
ENBREL® (etanercept)	25mg Vial	1x/week		
ENBREL® (etanercept)	25mg Prefilled Syringe	1x/week		
ENBREL® (etanercept)	50mg Prefilled Syringe	2x/week for 3 months; then 1x/week		New Enrollees - One year supply - Initial 3 month shipment, every two months for the remaining 9 months. Re-enrollees - One year supply - Shipments Every two months
ENBREL® (etanercept)	50mg SureClick	2x/week for 3 months; then 1x/week		
ENBREL® (etanercept)				

Enrollment Status: Temporary Medicaid (TM), Standard (S), 9 month (9 mth), Medicare (Mcare)

I have prescribed Enbrel® for the above patient. My patient gave consent for me to provide this information. I understand that no third party or patient should be billed or charged for Enbrel® provided by this program. I understand that no free product should be sold, traded, or distributed for sale.

X _____
Physician's Original Signature (stamps not accepted) Date

*Note: All shipments will be sent to the patient unless otherwise requested.

Completion of this form is part of the initial application process and does not guarantee enrollment in the ENCOURAGE FOUNDATION®. The ENCOURAGE FOUNDATION® will review the completed application to determine the patient's eligibility.



NOTARIZED INCOME STATEMENT

Only use this form if you cannot provide proof of income documentation.

Name: _____ SS#: _____ Date of Birth: _____

My estimated annual household income currently is \$ _____.
(Please include dollar amount)

- \$_____ Social Security Disability Income (SSDI) (Beginning ___/___)
- \$_____ Supplemental Security Income (SSI)
- \$_____ Aid from the Department of Public Welfare
- \$_____ Unemployment Benefits (From ___/___ to ___/___)
- \$_____ Workers Compensation Benefits (From ___/___ to ___/___):
- \$_____ Dividends, interest, or investment accounts
- \$_____ Employment (Myself and/or my spouse)
- \$_____ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household: _____

**YOU MUST HAVE THIS FORM NOTARIZED IN ORDER TO PREVENT A DELAY
IN THE PROCESSING OF YOUR APPLICATION.**

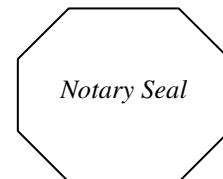
Patient Signature _____

Notary Seal

Date _____

Notary Signature _____

Date _____





ATTESTATION FORM

Only use this form if you cannot provide proof of income documentation.

Name: _____ SS#: _____ Date of Birth: _____

My estimated annual household income currently is \$_____.
(Please include dollar amount)

- \$_____ Social Security Disability Income (SSDI) (Beginning __/__)
- \$_____ Supplemental Security Income (SSI)
- \$_____ Aid from the Department of Public Welfare
- \$_____ Unemployment Benefits (From __/__ to __/__)
- \$_____ Workers Compensation Benefits (From __/__ to __/__)
- \$_____ Dividends, interest, or investment accounts
- \$_____ Employment (Myself and/or my spouse)
- \$_____ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household: _____

Patient Advocate/Physician Office Staff Attestation:

Physician office staff may sign below to attest to the patient's financial situation.

To the best of my knowledge , I know the financial information provided on this application to be true.

Print Name: _____

Title: _____

Original Signature: _____
(Stamps not ccepted)

Date:

Patient Signature: _____

Date: