CELGENE PATIENT SUPPORT®

Celgene Patient Support® Enrollment Form

Phone: 1-800-931-8691
Fax: 1-800-822-2496
Web site: www.celgenepatientsupport.com
E-mail: patientsupport@celgene.com

Online enrollment also available at www.celgenepatientsupport.com

PLEASE CHECK ALL SERVICES FOR WHICH YOU ARE APPLYING

Insurance-Related Services

- ❑ Benefits Investigation
- ❑ Prior Authorization/ Precertification Assistance
- ❑ Appeals Assistance
- ❑ Fast Track for First Prescription®

Financial Assistance

- ❑ Co-payment Assistance
- ❑ Celgene Free Medication Program
- ❑ Replacement Medication Program
- ❑ Transportation Assistance

PATIENT CLINICAL INFORMATION

Patient Name _____ Drug and Dosage _____

Diagnosis/ICD-10-CM _____ Start Date _____

Number of Prior Therapies for This Diagnosis _____ In Combination With (If applicable) _____

Names of Prior Therapies _____

HEALTHCARE PROFESSIONAL/FACILITY INFORMATION

Physician Name	DEA #	Tax ID #
Facility Name	NPI #	PTAN #
Address	**Contact Name/Title**	
City/State/Zip	**E-mail**	
Medicaid Provider #	**Phone**	**Fax**

PATIENT INSURANCE INFORMATION

If the patient has **Medicare**, please check all that apply: ❑ **Part A** ❑ **Part B** ❑ **Part D** ❑ **Medicare Advantage**

Medicaid: ❑ **Actively Enrolled** ❑ **Applied/Pending Coverage** ❑ **Denied** ***(Provide copy of Medicaid denial letter)*** ❑ **Never Applied** ❑ **I Don't Know**

Medical Insurance Company		**Prescription Drug Plan Name**		**Other** ❑ Secondary/Supplemental ❑ Veterans Affairs Benefits ❑ State Pharmaceutical Assistance Program
Name of Insured (Cardholder)		Name of Insured (Cardholder)		
Policy #	Group #	Policy #	Group #	Policy Name
Plan Phone		Plan Phone		Policy Phone
Member ID #		BIN #		Policy #
❑ Healthcare Marketplace Plan		PCN #		

Please copy the front and back of medical insurance and prescription drug plan cards and include with fax or e-mail.

I hereby represent, covenant, and certify as follows: (a) I have obtained from my patient all required authorization to release to Celgene Patient Support® 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 Patient Support® and its representatives/agents to assess the patient's eligibility for participation in Celgene Patient Support®; (c) I have not received, nor will I seek or accept reimbursement from any federal, state, or private payers for any drug provided for my patient by Celgene Patient Support® Free Medication Program or Replacement Medication Program; (d) I have not received, nor will I seek or accept payment from my patient for any co-insurance amount paid for by the Celgene Commercial Co-pay Program for a Celgene product; (e) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program. I will notify Celgene Patient Support® if I become aware of any such changes; (f) 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; (g) the information contained in this form is complete and accurate to the best of my knowledge; and (h) I will notify Celgene Patient Support® of any errors regarding the foregoing, and will make every effort to correct those errors.

Please provide a copy of this application to your patient for their records.

HEALTHCARE PROFESSIONAL SIGNATURE _____ **DATE** _____

Please fax to 1-800-822-2496, e-mail to patientsupport@celgene.com, or enroll online at www.celgenepatientsupport.com

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PATIENT INFORMATION

Patient's Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ E-mail _____

State _____ Zip _____ Sex: ❑ Female ❑ Male

Do you permanently reside in the US or a US territory? ❑ Yes ❑ No Birth Date _____ SS # _____

CAREGIVER INFORMATION (If Applicable)

Caregiver Name _____ Caregiver E-mail Address _____

Caregiver Phone _____ Relationship to Patient _____

PATIENT FINANCIAL INFORMATION (Required for Financial Assistance)

Patients may be subject to a random audit to verify income. Income must reflect amount for entire household.

Number of people living in household who contribute to or are dependent on your household income: _____

Average Gross Family Income (*Numerical value required*): $ _____ ❑ Yearly ❑ Monthly

Please check all that apply:

❑ Salary/wages ❑ Social Security ❑ Earnings from dividends

❑ Pension ❑ Disability start date _____ ❑ Earnings from rental property

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Celgene Patient Support® is a free service that provides you and your patients:

- A single Celgene Patient Support® Specialist assigned to your office
- Reduced co-pay responsibility of **$25 or less** for eligible patients taking Celgene medications
- Assistance obtaining insurance approval for Celgene medications

Call us at
1-800-931-8691
Monday – Friday, 8 AM – 7 PM ET

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