Patient Enrollment Form

Description of Services:
- Verification of Insurance Benefits/Drug Coverage
- Screening for Patient Assistance Program (PAP) eligibility

Phone: 1-888-537-8277
www.AcrotechPatientAccess.com

Acrotech Access Support™

PATIENT INFORMATION

First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Telephone:	Date of Birth:	Gender: ❑ Male ❑ Female
Gross Annual Household Income: $	Is the patient a U.S. Citizen or legal U.S. resident? ❑ YES ❑ NO	

CAREGIVER INFORMATION

First Name:	**Last Name:**	**Telephone:**

INSURANCE INFORMATION | PLEASE PROVIDE LEGIBLE COPIES (FRONT AND BACK) OF ALL MEDICAL AND PHARMACY INSURANCE CARDS

Does the patient have insurance? ❑ YES ❑ NO	Type of Insurance: ❑ Medicare ❑ Medicaid ❑ Commercial/Private ❑ TRICARE ❑ Other ❑ Uninsured
Has a Prior Authorization (PA) been initiated? ❑ YES ❑ NO	

MEDICAL INSURANCE	PHARMACY INSURANCE
Insurance Provider:	Insurance Provider:
Insurance Phone Number:	Insurance Phone Number:
Cardholder Name (if not the patient):	Cardholder Name (if not the patient):
Cardholder Date of Birth (if not the patient):	Cardholder Date of Birth (if not the patient):
Policy Number:	Policy Number:
Group Number:	Group Number:
BIN/PCN:	BIN/PCN:

PHYSICIAN INFORMATION

Treating Physician Name:	Tax ID #:	NPI:
Facility Name:	Street Address:	
City:	State:	Zip:
Office Contact:	Phone:	Fax:
Alternate Site of Care (if applicable):	Street Address:	
City:	State:	Zip:

MEDICATION AND PRESCRIPTION INFORMATION

Prescription for Patient Above - Check applicable drug.

❑ Beleodaq® (belinostat) for injection
❑ Folotyn® (pralatrexate injection)
❑ Evomela® (melphalan) for Injection
❑ Khapzory® (levoleucovorin) for injection
❑ Ryzneuta® (efbemalenograstim alfa-vuxw) for injection

***FOR NY PATIENTS:** Please also attach a prescription written on an Official New York State Prescription pad.

Dosage per treatment:	Frequency:
Quantity:	Refills:

List Patient Diagnosis and ICD-10-CM code(s):

List planned/future outpatient dates of service for drug:

List Patient's Current Medication:

List any allergies:

Prescriber Signature: **Date:**

**I have read the Physician Certification on Page 2 and affirm that its contents are true and correct to the best of my knowledge and professional judgement.

See Page 2. When Complete, Fax Form to 1-866-930-1562

ACRO-0167

ACROTECH® BIOPHARMA

Acrotech Access Support™

Patient Certification:

I certify that the information I have provided is truthful and accurate to the best of my knowledge. I understand that any assistance provided to me through Acrotech Access Support™ Patient Assistance Program (the "Program"), which is supported by Acrotech Biopharma, Inc., is contingent upon my ability to meet the eligibility criteria for the Program and that my application for assistance does not guarantee acceptance into the Program. Any assistance for which I may be eligible will only be awarded after my documentation has been received and approved by the Program. In the event that I am eligible for the Program, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Program. Assistance is not guaranteed for any specific time frame and may be terminated at any time for any reason without any notice to me. I agree that I will notify the Program within thirty (30) days if my insurance or financial situation changes as this may impact my eligibility to participate in the Program. The Program has the right to review its records periodically throughout a patient's enrollment period to verify that the enrolled patient continues to satisfy the eligibility criteria. If this review determines that the patient no longer satisfies the eligibility criteria, the Program will withdraw the patient from the Program. I certify that I have not received and will not seek to receive reimbursement for the Acrotech Biopharma Inc. drug requested and/or supplied through the Program. I agree that the Program and its affiliates, agents and representatives shall not be liable for any damages, of any kind, without limitation, in connection with my receiving assistance, benefits, or services provided by the Program. I have read, understand, and agree to all of the above.

Print Patient or Personal Representative* Name:

If Personal Representative, please state legal authority:

Patient or Personal Representative Signature: | **Date:**

*If signd by Personal Representative, we may contact you if additional documentation is required.

Patient Authorization to Use and Disclose Protected Health Information:

I authorize my healthcare providers, pharmacies and health plan(s) to disclose and redisclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to the Acrotech Access Support™ Patient Assistance Program (the "Program"), which is supported by Acrotech Biopharma, Inc., and its agents, administrators and service providers, for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition, including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Program field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) providing me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to the Program. I understand that I may cancel this Authorization at any time, by writing to CoverMyMeds, Attn: Acrotech Program, 910 John Street, Columbus, Ohio 43222 or calling 1-888-537-8277, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. FOR MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4), this authorization expires ONE YEAR from the date of signature. I understand that once my information is disclosed, it may be subject to re-disclosure by the recipients and no longer protected by federal privacy law. Additionally, I understand that nonidentifiable information from all Program participants may be summarized for statistical or other purposes, but my identity cannot be determined from this summary information.

I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Print Patient or Personal Representative* Name:

If Personal Representative, please state legal authority:

Patient or Personal Representative Signature: | **Date:**

*If signd by Personal Representative, we may contact you if additional documentation is required.

Financial Information and Fair Credit Reporting Act ("FCRA") Authorization:

I understand that I am providing "written instructions" under the FCRA to the Acrotech Access Support™ Patient Assistance Program (the "Program"), which is supported by Acrotech Biopharma, Inc., and its agents, administrators and service providers, authorizing the Program to obtain information from my credit profile and/or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by the Program. I understand that I must affirmatively agree to these terms in order to proceed with this financial screening process.

Print Patient or Personal Representative* Name:

If Personal Representative, please state legal authority:

Patient or Personal Representative Signature: | **Date:**

*If signd by Personal Representative, we may contact you if additional documentation is required.

Physician Certification:

On behalf of my patient, I request assistance for the 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 based upon my professional judgment, the drug I have prescribed and specified in this application is medically necessary. I authorize the Acrotech Access Support™ Patient Assistance Program (the "Program"), which is supported by Acrotech Biopharma, Inc., and its agents, administrators and service providers, to forward, as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with the Program. Should any information contained in this form change, I agree to notify a Program representative. I understand that the patient must meet certain financial criteria to be eligible under the Program and that completing this enrollment form does not guarantee that assistance will be provided to my patient. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested and/or supplied under the Program and any administration charges will be consistent with my practice's standard policies for treatment of and charges to financially needy patients. 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 Acrotech Biopharma Inc. reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug.

Fax Completed Form to 1-866-930-1562