CELGENE PATIENT SUPPORT®

Celgene Patient Support® Enrollment Form

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

Online enrollment 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

- ❑ Celgene Commercial Co-pay Program
- ❑ Information on Independent Third-party Co-pay Assistance Organizations
- ❑ Celgene Patient Assistance Program (PAP)

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 insurance, please check all that apply: ❑ **Commercial/Private Insurance**

Medicare: ❑ **Part A** ❑ **Part B** ❑ **Part D** ❑ **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 his or her consent and any 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 Assistance Program (PAP); (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 Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ E-mail _____

State _____ Sex: ❑ Female ❑ Male

Zip _____ Birth Date _____ SS # _____

Do you permanently reside in the US or a US territory? ❑ Yes ❑ No

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 their gross annual household income. Income must reflect amount for entire household.

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

Gross annual household income* (*Numerical Value Required*): $ _____ ❑ Yearly ❑ Monthly

*Gross household income is the total income before income tax deductions from all people living in your household. Gross income refers not only to the salaries and benefits received, but also to the receipts from any personal business, investments, dividends, and other income.

Please check all that apply:

❑ Salary/Wages
❑ Pension
❑ Unemployment Benefits/Workers' Compensation
❑ Alimony
❑ Supplemental Security Income (SSI)
❑ Social Security Disability Income (SSDI)
SSDI Start Date: _____
❑ Earnings From Dividends
❑ Earnings From Rental Property

Celgene Patient Support® provides:

- A single Specialist assigned to help patients in your geographic area
- Assistance with understanding patient insurance coverage for Celgene medications
- Information about financial assistance for prescribed Celgene medications

Call us at
1-800-931-8691
Monday – Thursday, 8 AM – 7 PM ET,
and Friday, 8 AM – 6 PM ET
(translation services available)

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