



ASAP ENROLLMENT FORM
 Complete and fax to 1-877-801-0777 or mail to:
 Allos Support for Assisting Patients (ASAP)
 c/o AccessMed
 6900 College Blvd.
 Suite 1000
 Overland Park, KS 66211

PHYSICIAN INFORMATION

Physician Name:	State License #:	
Name of Group/Hospital:	Tax ID #:	NPI:
Correspondence Address:		
City:	State:	Zip:
Office Contact Name:	Phone: ()	Fax: ()
Shipping Address (if different than above)		
City:	State:	Zip:
Treatment Start Date:	Diagnosis/ ICD-9-CM:	

PATIENT INFORMATION

First Name:	Last Name:	
Correspondence Address:		
City:	State:	Zip:
SSN: - -	Date of Birth: / /	Telephone: ()
Annual Household Income:	Number in Household:	
Annual Medical Out of Pocket Expenses:	Alternate Contact Name/Phone number:	

INSURANCE INFORMATION:

*** Please provide copies of all insurance cards (front/back) ***

Does the patient have Health Coverage: YES NO **Does the patient have Medicare Coverage:** YES NO
 If Medicare, check all that apply: Part A Part B Part D
 Medicare Policy # : _____ Effective Date: _____

If has Part D, list Prescription Drug Plan information below

Insurance Name:	Policy ID Number:
Telephone:	
Private Primary Insurance: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Insurance Name:	Policy ID Number:
Telephone:	
Secondary Insurance: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Insurance Name:	Policy ID Number:
Telephone:	
Veterans/Medicaid/Other Insurance: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Insurance Name:	Policy ID Number:
Telephone:	

DRUG REQUESTED : _____ *If you have any questions, please contact us at 1(877) ASAP102 (272-7102)*

Patient Acknowledgment and Consent
 The ALLOS SUPPORT for ASSISTING PATIENTS (ASAP) program is a service of Allos Therapeutics, INC. Collection of certain insurance, financial, and medical information is necessary in order to evaluate your enrollment into the program and, if enrolled, to provide you program services. The program services include verifying your insurance benefits, identifying potential alternative benefits for which you may be eligible, and/or evaluating you for participation in the ASAP program. Except as discussed below, and except as permitted or required by law, this private medical, insurance, and financial information will be kept confidential and will not be shared with any third parties. Your information may be shared or disclosed in order to fully evaluate you for initial and continued enrollment in the program as well as your eligibility for other programs, including to the National Organization for Rare Diseases (NORD). For example, personal information may also be shared with physicians and health insurers in order to provide you with program services. In addition, we are required to report certain personal information to Allos Therapeutics, Inc. in order to comply with FDA reporting requirements. If you have included an alternate contact name, you authorize ASAP to contact them to assist in processing your enrollment. Finally, nonidentifiable information from all program participants may be summarized for statistical or other purposes, but your identity cannot be determined from this summary information. By signing below, and enrolling in ASAP, you hereby (i) authorize any and all disclosures of your identifiable health/financial/insurance information as set forth in this paragraph, and (ii) consent to such disclosure.

Patient Name (please print)	_____
Patient Signature (Required)	_____ Date _____
Provider Name (please print)	_____
Provider Signature (Required)	_____ Date _____
Legal Representative/Guardian Signature (If applicable)	_____ Date _____