



**Allos Support for Assisting Patients
Enrollment Form**
Complete and fax to 1-877-801-0777
 6900 College Blvd. Suite 1000 Overland Park, KS 66211
 Phone: 1-877-ASAP102 - <http://getasapinfo.com>

PRESCRIBING PHYSICIAN INFORMATION

First Name:		Last Name:		State License #:	NPI:
Name of Group/Hospital:				Tax ID #:	PTAN:
Correspondence Address:					
City:			State:		ZIP:
Office Contact Name:			Phone:		Fax:
Shipping Address (if different than above)					Email:
City:			State:		ZIP:
FOLOTYN® (pralatrexate injection) Prescription for Patient Below	Dosage per treatment:	Frequency:	List Patient Diagnosis: _____ and ICD-9-CM code: _____		
List past outpatient dates of service for FOLOTYN in last 60 days for patient below:			List planned/future outpatient dates of service for FOLOTYN for patient below:		

PATIENT INFORMATION - Please provide proof of income if requesting free product

First Name:		Last Name:			
Correspondence Address:					
City:			State:		ZIP:
SSN:			Date of Birth:		Telephone:
Gross Annual Household Income: \$			Number of People in Household:		
Annual Medical Out of Pocket Expenses: \$			Is patient a U.S. Citizen or legal U.S. resident? <input type="checkbox"/> YES <input type="checkbox"/> NO		

INSURANCE INFORMATION - Please provide copies of all medical and pharmacy insurance cards (front and/back) **

Does the patient have medical benefits and/or pharmacy benefits through any private or government health insurer/payer/program?
 YES NO If "YES", please complete all that apply below:

Type of Insurance - "X" if Yes	Name of Insurer/Plan	Policy ID #:	Group # (if applicable)	Insurance Phone #
<input type="checkbox"/> Medicare Part A				
<input type="checkbox"/> Medicare Part B (Fee-for-Service/Original Medicare)				
<input type="checkbox"/> Medicare Part C – (Medicare Advantage)				
<input type="checkbox"/> Medicare Part D Drug Plan				
<input type="checkbox"/> Private Insurance - Medical (Primary)				
<input type="checkbox"/> Private Insurance – Medical (Secondary)				
<input type="checkbox"/> Private – Pharmacy Benefits Manager				
<input type="checkbox"/> Medicaid				
<input type="checkbox"/> Veterans Affairs				
<input type="checkbox"/> TRICARE				
<input type="checkbox"/> Other insurance				

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, researching denied or underpaid claims, 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, pharmacists, 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 and PHYSICIAN SIGNATURES

Patient Name (print) _____	Patient Signature (required) _____	Date _____
Legal Representative/Guardian Signature (If applicable) _____	_____	Date _____
Prescribing Physician Name (print) _____	Prescribing Physician Signature (required) _____	Date: _____