



FAX

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Instructions for Community Access Patient Program (CAPP) Confidential Application Form:

AccessMED has been retained by EUSA Pharma to review CAPP applications and determine a patient’s benefits and if they have available resources to purchase prescribed medication.

CAPP will determine if the patient has no coverage and might be eligible for free product for Erwinaze™(asparaginase *Erwinia chrysanthemi*), Quadramet® (Samarium Sm 153 Lexidronam Injection), ProstaScint® (Capromab Pendetide), and Caphosol® (supersaturated calcium phosphate rinse). The CAPP eligibility is based on the patient’s inability to access medication due to lack of insurance coverage including disqualification from government programs, and whose total family income is at or below 400% of the Federal Poverty Level as defined by the Department of Health and Human Services (HHS) in their Annual Update on the HHS Poverty Guidelines found at <http://aspe.hhs.gov/poverty/>. Any denials for assistance may be re-considered by asking for an eligibility appeal.

CAPP also has counselors available to investigate alternative coverage, such as co-pay assistance or premium assistance foundations, State or Federal sponsored programs, or other forms of assistance that might be available.

To ensure your application is processed accurately, please be sure that:

- All sections of the application are complete
- The patient and physician have signed and dated the Application Form
- The physician’s NPI is included on the form in the field indicated if you wish CAPP to investigate these benefits on the patient’s behalf.
- If you are seeking assistance with free product, please include a copy of the facility or physician’s state license for shipping purposes.**
- If you are seeking assistance with free product, please include proof of income of the patient and the patient’s family or guardian as listed on the application. Proof of income includes:** Copy of Federal tax return, W-2, copy of month of recent paystubs, copy of Social Security check or awards letter, etc.

Please note that incomplete applications cannot be processed and will be returned to you.

Any denials for assistance may be reviewed by asking for an eligibility appeal. Please contact your CAPP Representative with any questions at **888-837-4397**. Operating Hours are **Monday – Friday 8:00 AM – 5:00 PM CST**

PLEASE FAX COMPLETED FORM TO: 1-866-287-3036

EUSA Pharma reserves the right to change eligibility guidelines, terminate, or modify this program at any time for any reason including the period of drug assistance and the quantities given.



EUSA Pharma

Community Access Patient Program (CAPP)

6900 College Boulevard, Suite 1000

Overland Park, Kansas 66211

Phone: 888-837-4397 ♦ Fax: 866-287-3036

EUSA Pharma@AccessMED.com

PATIENT NAME: _____		CASE #: _____	
Physician Name _____		DEA # _____	
NPI # _____		Medical License _____	
Facility Name _____		Tax ID # _____	
Address (No PO Boxes) _____			
City _____		State _____	Zip _____
Clinic Contact _____		Contact Title _____	
Contact Phone _____		Ext _____	Secure Fax _____

Prescribing Information (Please print or type)					
Patient Diagnosis (ICD-9) _____		ICD-9 Description _____			
Therapy is being provided in: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient Facility					
Is doctor contracted with patient's insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Product Requested:	Dose:	Frequency:	Quantity:	Treatment Date(s) GIVEN	Treatment Date(s) PLANNED
<input type="checkbox"/> QUADRAMET®					
<input type="checkbox"/> PROSTASCINT®			# kits:		
<input type="checkbox"/> CAPHOSOL®			# 120 Dose Dispensing Pack:		
<input type="checkbox"/> ERWINAZE™			# of 5-pack kit (s):		

If shipping address is the same as the mailing address above, please confirm by checking the box. If not, please indicate shipping address below. <input type="checkbox"/> Shipping Address Is Same As Mailing Address	
Shipping Address _____	
City _____	State _____
Zip _____	

Physician / Prescriber Attestation

I certify that the drug subject to this application is medically necessary for this patient for the drug's labeled indication and that the information stated herein, as well as the documentation furnished in support of this application, is accurate to the best of my knowledge. If the patient is enrolling in the Patient Assistance Program, I certify that to the best of my knowledge and upon due diligence, the patient referenced above is unable to afford the medication and does not have, or qualify for, coverage under any Federal healthcare program, including Medicare and Medicaid. I acknowledge my responsibility for receiving the product, storing it separately under manufacturer's recommended conditions and providing it for the outpatient treatment of this patient only.

Original Signature of Licensed Practitioner (no stamps accepted) _____ Date _____

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EUSAPharma@AccessMED.com



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Patient Name _____	Date of Birth _____
Phone _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number _____	US Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address _____	
City _____	State _____ Zip _____
Alt. Contact Name/Phone _____	Relationship to Patient _____
Number of people in your household? _____ (to include you, your spouse, legal guardians, and dependents)	
Annual gross family income (before taxes) \$ _____ (To include salary, pension, unemployment or worker's comp, Social Security, disability, alimony, child support, interest/dividends, rental property, etc.)	
Do you have any health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What type of insurance coverage do you have? (Check all that apply)	
<input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid <input type="checkbox"/> Veterans <input type="checkbox"/> State Program <input type="checkbox"/> Employer <input type="checkbox"/> Other _____ (Please fill in name of Insurer)	
Provide copies of all insurance cards enlarged, front and back	
For each policy you have, please attach a copy of both sides of your insurance card complete following:	
Primary Insurance _____	Secondary Insurance _____
Phone Number _____	Phone Number _____
Policy ID _____	Policy ID _____
Group # _____	Group # _____
Policy Holder _____	Policy Holder _____
Have you recently received a Denial Letter for this product? <input type="checkbox"/> Yes <input type="checkbox"/> No → If Yes, please attach the denial letter.	
Have you applied to Medicaid? <input type="checkbox"/> Not applied <input type="checkbox"/> Pending <input type="checkbox"/> Denied	
Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No → If Yes, have you applied for VA benefits? <input type="checkbox"/> Not applied <input type="checkbox"/> Pending <input type="checkbox"/> Denied	

I understand that EUSA Pharma's and the Community Access Patient Program (CAPP) and its agents will treat this information confidentially in accordance with their privacy policies. I authorize, which authorization shall remain in effect for one year from the date hereof, my provider and any health insurance plan, to disclose to EUSA Pharma's Community Access Patient Program (CAPP), and/or their representatives, information about my medical condition, treatment, and insurance coverage (for example, my diagnosis, medical history, and insurance coverage limitations) as needed to evaluate and determine eligibility for coverage under the terms of my health insurance policy or potential coverage options. Further, I consent to being contacted by EUSA Pharma CAPP with respect to supporting the benefit investigation process. I verify that the information provided in this form is complete and accurate. I understand that EUSA Pharma CAPP reserves the right at any time, and without notice, to modify the application forms, change eligibility guidelines or otherwise terminate or modify the program at any time or any reason. I authorize EUSAPharma and its agents to obtain information from prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this form.

Patient/Guardian Signature _____ Date _____

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