MGI PHARMA Access Program
P.O. Box 4133 Gaithersburg. MD 20885-4133

Phone: 877-MGI-MAP0
(644-6270)
Fax: 888-644-7236

GLIADEL® ENROLLMENT FORM

PRESCRIBER INSTRUCTIONS

Service(s) Requested: □ **Insurance Verification/Pre-certification** □ **Patient Assistance**
Site of Service: □ **Hospital Inpatient** □ **Other ___________**

IMPORTANT: Please provide the physician's Tax ID and State License or DEA number with expiration date.

1. For consideration to determine if your patient is eligible for the MGI PHARMA Access Program please complete the application form.
2. Request that the patient complete page two of the application. Forward the form to the address or fax indicated on the form.
3. **Financial information is NOT needed for an insurance verification or pre-certification.** However, if applying for patient assistance, financial information is required.
4. MGI PHARMA Access Program will determine if your patient is eligible for patient assistance or if the patient has reimbursement to cover the product.
5. If the patient is eligible to participate in the patient assistance program, your office will receive a letter of acceptance via fax. There will be a request form attached to indicate the exact number of wafers and boxes used. There will be no charge to your patient. (Shipment is typically within 24-72 hours after receiving the replacement form and necessary documentation)
6. If the patient's eligibility for the patient assistance program is denied, your office will receive a denial letter via fax.

PHYSICIAN/FACILITY INFORMATION (Please print)

Physician Name:		**Specialty**
Hospital Name		
Contact Name (if different from physician)	**Contact Phone Number**	
Address		
City	**State**	**Zip Code**
Phone Number	**Fax Number**	
Tax ID	**State License No.**	**Issuing State**

GLIADEL® INFORMATION

PATIENT NAME:	**PATIENT DATE OF BIRTH:**
DATE OF SURGERY:	**NUMBER OF WAFERS/ BOXES USED:**

Diagnosis ______________________________ ICD-9 Code: ______________

Patient's physician to acknowledge and represent thereon that such physician will not distribute or provide product received under the Program to any person other than the intended patient and will not charge such patient for such product.

To the best of my knowledge, this patient does not have any insurance coverage (including private insurance, Medicare, Medicaid, county funded assistance, or other public programs) for the product, if applying for patient assistance.

No claim may be made to any third party payer for payment of product provided under the Program, if product is received via patient assistance or drug replacement. Product provided under the Program must only be used for the approved patient and may not be sold, traded or returned for credit.

Please indicate that you agree to these terms by signing below. Failure to comply with these terms may mean you (and any patients you treat) will no longer be eligible to participate in the MGI PHARMA Access Program. Your signature confirms that there is a valid medical need for this patient's treatment.

Physician Signature: ______________________________ Date: ______________

PLEASE FAX COMPLETED APPLICATION AND APPLICATION DOCUMENTATION TO 1-888-644-7236

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GLIADEL® ENROLLMENT FORM (page 2)

PATIENT INFORMATION (Please print)

US Resident: ❑ Yes ❑ No SSN/ID No. ____________ Phone Number ____________

Patient Name ____________ Date of Birth ____________

Address ____________

City ____________ State ______ Zip ____________

Employment Status: ❑ Employed ❑ Unemployed ❑ Self-employed ❑ Retired Gender: ❑ M ❑ F

INSURANCE INFORMATION (attach a copy of insurance cards, if available) ❑ Check if uninsured

Primary Insurance:	Secondary Insurance:
Insurance Phone #:	Insurance Phone #:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's SSN:	Policy Holder's SSN:
MD's Provider # (if applicable):	MD's Provider # (if applicable):

FINANCIAL INFORMATION (Only complete if applying for Patient Assistance Program)

Total Annual Adjusted Gross Income $ ____________ **Household Size (include patient)** ____________

APPLICANT DECLARATION

I certify that the information provided in this form is correct and complete. If needed, MGI PHARMA, Inc. ("the Company") and the MGI PHARMA Access Program ("the Program") may request and obtain information about my, or my family's income to enroll me in the Program. I understand that I will need to reapply to this Program every twelve months.

Permission for Sharing Personal Health Information:

To confirm that I qualify for the Program, my doctor may give a representative of the Program information about my health. My insurer and employer may give the Program information about my insurance. People who work for and with the Company to run the Program may see my health and insurance information and the information on this form, but they may use it only for this Program. The Program will make every effort to keep my information confidential, but if it is accidentally disclosed, federal privacy laws will not protect it. This permission will last for one year from the time I apply to the Program. If I change my mind before one year has passed, I can call the Program's toll-free phone number and tell them that I have decided to leave the Program. I can also inform my doctor, insurer, or employer in writing that I do not want them to give the Program any more information. I know that this means I may no longer be able to receive assistance from the Program. I also understand that the Company has the right to change or end the Program without prior notification to me.

I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits.

X ____________

Signature of Patient or Patient Representative (if signed by Representative, explain authority to act for the Patient)

____

Name (print) Date

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