



VELCADE® (bortezomib) REIMBURSEMENT ASSISTANCE PROGRAM

Please complete the information below and fax to the VELCADE Reimbursement Assistance Program at (800) 891-9843 or mail to PO Box 52100, Phoenix, AZ 85072. Questions regarding this application may be addressed to the VELCADE Reimbursement Assistance Program at (866) 835-2233, option 2.

Requested Program Service: Patient Assistance Program Enrollment Transportation Assistance* Insurance Verification All
*Please select transportation assistance if the patient needs assistance finding local transportation in connection with receiving therapy.

Patient Information

Patient Name: _____
Date of Birth: _____ SSN: _____
Mailing Address: _____
City: _____ State: _____ ZIP: _____
Telephone: _____
Have you ever applied for Medicaid? Yes No
If no, please explain: _____
If Yes and your application was rejected, explain reason for rejection: _____

Patient Clinical Information

Patient Diagnosis : _____
ICD-9 Code: _____
Previous Therapies: _____
Site of Service: Physicians Office Hospital Outpatient Clinic
 Hospital Inpatient.

Patient Financial Information

(To be completed for Patient Assistance Program applications - Please attach income documentation for each of the sources checked below. We are unable to process your application without the required information. Documentation can include the previous year's Federal Tax Return, W2 Form, Check Stubs (3 months), etc.)

Current annual household income: \$ _____
Number of dependents within household (include applicant): _____
Source of Income: Wages Family Public Assistance SSI/SSDI
 Other (Please explain): _____

Patient Declaration

Financial Statement: I certify that the information provided in this form is correct and complete. If needed, Millennium Pharmaceuticals, Inc. ("the Company") and the Patient Assistance 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 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.

Patient or Representative Signature: _____
(If signed by representative, explain authority to act for the patient)
Name: _____ Date: _____

Insurance Information

Do you have any type of health insurance, including public programs such as Medicare, Medicaid, or any other assistance programs? Yes No
(If yes, please complete below)

Primary Insurance: _____

Policy Holder Name: _____

Policy ID #: _____ Group #: _____

Telephone: _____ Date of Birth: _____

Secondary Insurance: _____

Policy Holder Name: _____

Policy ID #: _____ Group #: _____

Telephone: _____ Date of Birth: _____

If applicable, please include the physician's payer-specific provider number: _____

Has coverage for VELCADE therapy been specifically denied?

No Yes (Please explain): _____

Physician Information

Physician Name: _____

Site Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Office Contact: _____ Fax: _____

Phone: _____ Best Time to Call: _____

NPI #: _____

Tax ID #: _____

State License #: _____ Expiration Date: _____

Shipment Address (if different from above): _____

City: _____ State: _____ ZIP: _____

Provider Declaration

To the best of my knowledge, this patient does not have any drug coverage (including private insurance, Medicare, Medicaid, county funded assistance, or other public programs) for VELCADE® (bortezomib) for injection that has not been declared on this form.

If a patient is approved for the Patient Assistance Program, no claim may be made to any third party payer for payment of product provided under the Patient Assistance Program. Product provided under the Patient Assistance Program must only be used for the approved patient and may not be sold, traded or returned for credit. The VELCADE Reimbursement Assistance Program requests that physicians do not charge the patient for those professional services associated with this regimen that are not covered by the patient's health insurer.

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 VELCADE Reimbursement Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature: _____

Physician Name (Print): _____ Date: _____