



**VELCADE 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 221087 Charlotte, NC 28202-1087. Questions regarding this application may be addressed to the VELCADE Reimbursement Assistance Program at (866) 835-2233.

Requested Program Service:  Patient Assistance Program Enrollment  Insurance Verification  Both

**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 applications only)  
 Current annual household income: \$ \_\_\_\_\_  
 Number of dependents within household (include applicant): \_\_\_\_\_  
 Source of Income:  Wages  Family  Public Assistance  SSI/SSDI  
 Other (Please explain): \_\_\_\_\_  
 \*Income documentation will be required in order to assess Patient Assistance Program eligibility (i.e., Previous Year Federal Tax Return, W2 Form, Check Stub (3 months), etc.)

**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 Insurer:** \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_  
 Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
**Secondary Insurer:** \_\_\_\_\_  
 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.  
 No claim may be made to any third party payer for payment of product provided under the Program. Product provided under the 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: \_\_\_\_\_