APPLICATION FOR ASTELLAS ACCESS PROGRAM℠ FOR DERMATOLOGY THERAPIES AMEVIVE® (ALEFACEPT)

Please fax completed application including income documentation to Astellas Access Program℠ for Dermatology Therapies: **1-866-420-8888**
If you have any questions call **1-866-AMEVIVE (1-866-263-8483)** Monday through Friday between 9 AM and 8 PM ET.

PATIENT INFORMATION

Name First: Last: **Date of Birth:**

SSN: Gender: ☐ M ☐ F

Mailing Address:

City: State: ZIP:

Daytime Phone: Evening Phone:

Shipping Address:

City: State: ZIP:

(If different than mailing address above—No PO Boxes, please)

MEDICAL INFORMATION

Severity: ☐ Moderate ☐ Severe **BSA Covered:** %

Diagnosis Code: ☐ 696.1—Other psoriasis and similar disorders **Date of Diagnosis:**

PHYSICIAN INFORMATION

Physician Name First: Last:

Physician DEA #: Physician License #: Physician NPI:

Office Contact Name First: Last: Title:

Telephone: Extension: Fax:

Facility/Practice Full Facility Name:

Address:

City: State: ZIP:

PRESCRIPTION FOR DERMATOLOGY THERAPY

In order for us to send medication to your patient, the prescription information must be complete and accurate. Please complete the prescription form and submit with page one of the application.

Patient Name: **Date of Birth:**

Amevive Strength: 15 mg for intramuscular injection

Dosing Instruction (check boxes for prescription quantity—maximum of a 12-week supply):
☐ Initial administration pack (4-week supply)
☐ First refill (4-week supply)
☐ Second refill (4-week supply)

Physician's Original Signature (stamps not accepted) **Date**

Astellas Reimbursement Services™

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PATIENT INSURANCE INFORMATION

Please complete the following section and **attach a photocopy of both sides of patient's insurance card(s)** (if applicable). **Check all that apply.**

Insurer

☐ Medicare B ☐ Medicare D ☐ Medicaid ☐ Private ☐ Other

☐ No Insurance (Patient is uninsured, no third party public or private insurance)

Payer Name: Plan Name: Patient ID #:

Group Plan #: Policy Holder's Name:

Phone Number: Payer Provider Number (Medicaid required):

FINANCIAL INFORMATION

Size of Household: Gross Family Annual Income*: Gross Family Annual Medical Expenses:

*Provide proof of gross annual household income, documented by a copy of the patient's most recent tax return; if taxes are not files, a copy of the patient's 1099 Social Security form, a copy of the most recent Social Security benefit letter, or a copy of recent paycheck stubs for a consecutive 30 day period may be supplied.

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND ENROLLMENT IN THE ASTELLAS ACCESS PROGRAM℠ (AAP) FOR DERMATOLOGY THERAPIES

I, the patient, fully understand and agree to the terms and conditions of the AAP. I affirm that I have a stable shipping address in the United States where I can receive Amevive provided to me through this program. I acknowledge that this is an assistance program of "last resort" and I have exhausted all other means to obtain Amevive. I understand that no third party can be charged for the Amevive provided under this program and that I will not submit a claim for reimbursement (or for purposes of counting it toward my true out of pocket expenses) to any payer. By signing this Authorization, I authorize my physician and my health insurance company to disclose to Astellas Pharma US, Inc., its affiliates and its representatives ("Astellas") personal information relating to my medical condition, treatment and insurance coverage that is needed to verify my insurance coverage for Amevive. I understand that once my information has been disclosed to Astellas, Astellas may share this information with others. Astellas agrees to protect my information by using and disclosing it only for the purposes authorized in this form. I also would like to enroll in the AAP. I understand that I am entitled to a copy of this Authorization upon request. I understand that Astellas reserves the right to change or terminate this program at any time, or to refuse to provide Amevive under this program to any patient and will not ship Amevive outside of the United States. I understand that I may refuse to sign this Authorization and choose not to participate in the AAP and that I may cancel this Authorization at any time by mailing a letter to: Astellas Access Program for Dermatology Therapies, PO Box 13185 La Jolla, CA 92039. Canceling this Authorization will end my enrollment in AAP and prevent future disclosure of my information to Astellas after the date Astellas receives my letter. Astellas' past use of my information will not be affected. This Authorization expires five years from the date it is signed by me.

Patient's Signature **Date**

Parent or Guardian Signature (For patients 17-18 yrs) **Date**

PHYSICIAN CERTIFICATION AND CONSENT FOR THE ASTELLAS ACCESS PROGRAM℠ (AAP) FOR DERMATOLOGY THERAPIES

I will sign applications to the AAP only for patients for whom I have determined that Amevive is medically appropriate. I agree to allow Astellas Pharma US, Inc., its affiliates and its representatives ("Astellas") to review the medical, financial, and insurance records for program patients at any time for the purpose of verification of insurance coverage. I understand that Astellas reserves the right to change or terminate this program at any time, or to refuse to provide Amevive under this program to any patient. I understand that no third party or patient can be charged for Amevive provided under this program and that no free product should be sold, traded, or distributed for sale. I also understand that provision of free drug as part of this program is not contingent upon future purchase or prescribing of Amevive or any other Astellas product. I agree to notify the program if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status or the indication for which has been prescribed for this patient.

Physician's Signature **Date**

FOR FULL PRESCRIBING INFORMATION SEE WWW.ASTELLAS.COM OR CONTACT ASTELLAS MEDICAL INFORMATION AT 1-800-727-7003.

Astellas Reimbursement Services

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