

APPLICATION FOR ASTELLAS ACCESS PROGRAMSM PROGRAF[®] (TACROLIMUS CAPSULES)

Please fax the completed application including **income documentation and patient financial worksheet** to Astellas Access Program:
1-866-317-6235

PATIENT INFORMATION

Name First:	Last:	SSN:	Sex:
Mailing Address:			
City:	State:	ZIP:	
Daytime Phone:	Evening Phone:		
Shipping Address:			
City:	State:	ZIP:	

MEDICAL INFORMATION

Transplant Type:	Transplant Date:	Date Prograf therapy began:
Transplant Paid by:	Known Allergies:	
Name other immunosuppressive drugs patient is taking:		

INSURANCE INFORMATION

Please complete the following table and **attach a photocopy of both sides of patient's insurance card(s)** along with this application.
Check all that apply.

Insurer	Status/Name	Coverage	Effective Date
<input type="checkbox"/> Medicare B	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	<input type="checkbox"/> Rx <input type="checkbox"/> Prograf	/ /
<input type="checkbox"/> Medicare D	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	<input type="checkbox"/> Rx <input type="checkbox"/> Prograf	/ /
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	<input type="checkbox"/> Rx <input type="checkbox"/> Prograf	/ /
<input type="checkbox"/> Private	Plan name:	<input type="checkbox"/> Rx <input type="checkbox"/> Prograf	/ /
<input type="checkbox"/> Other	Plan name:	<input type="checkbox"/> Rx <input type="checkbox"/> Prograf	/ /
<input type="checkbox"/> No Insurance	The patient does not have and is not eligible for any public or private health insurance.		

FINANCIAL INFORMATION

Size of Household:	Gross Family Annual Income:	Gross Family Annual Medical Expenses:
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PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND ENROLLMENT IN THE ASTELLAS ACCESS PROGRAMSM (AAP)

I, the patient, fully understand and agree to the terms and conditions of the AAP. I acknowledge that this is an assistance program of "last resort" and I have exhausted all other means to obtain PROGRAF. I understand that no third party can be charged for the PROGRAF provided under this program and I commit 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 agents ("Astellas") personal information relating to my medical condition, treatment, and insurance coverage. 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. I understand that Astellas reserves the right to change or terminate this program at any time, or to refuse to provide PROGRAF under this program to any patient. 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, P.O. 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 (5) years from the date it is signed by me.

Patient's Signature _____ Date _____

Parent or Guardian Signature (For patients under 18 yrs) _____ 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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PHYSICIAN INFORMATION

Physician Name First: _____ Last: _____

Contact Person Name (other than physician): _____

Title: _____

Facility/Practice Full Facility Name: _____

Telephone: _____ Fax: _____

Physician DEA #: _____ Physician License #: _____

PRESCRIPTION FOR PROGRAF

In order for us to send medication to your patient, the prescription information must be complete and accurate.

Please note: There are two enrollment periods—12 months (for uninsured, Medicare B, and private); current date through the end of the calendar year (Medicare Part D). Please complete the prescription below accordingly.

Patient Name: _____ Date of Birth: _____

PROGRAF Strength **Frequency** (please insert number of capsules)

0.5 mg caps BID : TID: Other: _____

1 mg caps BID : TID: Other: _____

5 mg caps BID : TID: Other: _____

Total Daily Dose: _____

Total Caps Dispensed: _____

Refills: _____

Physician's original signature (stamps not accepted) _____ Date _____

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

I will sign applications to the AAP only for patients for whom I have determined that PROGRAF is medically appropriate. I agree to allow Astellas Pharma US, Inc., its affiliates and its agents ("Astellas") to review the medical, financial, and insurance records for program patients at any time for the purpose of verification. I understand that Astellas reserves the right to change or terminate this program at any time, or to refuse to provide PROGRAF under this program to any patient. I understand that no third party or patient can be charged for PROGRAF 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 PROGRAF 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 PROGRAF has been prescribed for this patient.

Physician's Signature _____ Date _____

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