

APPLICATION FOR ASTELLAS ACCESS PROGRAMSM FOR DERMATOLOGY THERAPIES PROTOPIC[®] (TACROLIMUS) OINTMENT

Please fax completed application including income documentation to Astellas Access ProgramSM for Dermatology Therapies: **1-866-420-8888**
If you have any questions call **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: 373.31—Non-infectious dermatoses of eyelid 380.22—Eczema, external ear
 691.8—Other atopic dermatitis and related conditions 692.9—Contact dermatitis and other eczema where no cause is specified

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:** _____

Protopic Ointment Strength:	Dosing Instruction (please insert number of times to be applied daily):		
<input type="checkbox"/> 0.03% (30 g tube(s))	<input type="checkbox"/> Apply to affected area twice daily (Fill for a 90-day supply)	<input type="checkbox"/> Apply to affected area	daily
<input type="checkbox"/> 0.10% (30 g tube(s))	<input type="checkbox"/> Apply to affected area twice daily (Fill for a 90-day supply)	<input type="checkbox"/> Apply to affected area	daily

Total Quantity (Maximum of 3 tubes for 3 months): _____

Refills (Maximum of 3 refills): _____

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 filed, 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 PROGRAMSM (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 Protopic 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 Protopic. I understand that no third party can be charged for the Protopic 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 Protopic. 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 Protopic under this program to any patient and will not ship Protopic 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 under 18 yrs) **Date**

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

I will sign applications to the AAP only for patients for whom I have determined that Protopic 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 Protopic under this program to any patient. I understand that no third party or patient can be charged for Protopic 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 Protopic 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.



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