

**RapAssist® Patient Assistance Program and Reimbursement Hotline  
Patient Assistance Program Application**

Please complete this form to the fullest extent possible and fax the completed form to the RapAssist Program at 1-800-378-7645. This form may be used to inquire regarding your patient's coverage for Rapamune or to apply to the Patient Assistance Program. If you have any questions, please call 1-877-4-RAPAMUNE (1-877-472-7268).

Requested services:  Insurance Verification       Patient Assistance Program

**RapAssist Patient Assistance Program and Reimbursement Hotline**  
PO Box 220907 Charlotte NC 28222-0907  
Phone: 877-4-RAPAMUNE (1-877-472-7268), Fax: 800-378-7645

**Physician Information**

Physician Name: _____	Office Contact Name: _____
DEA #: _____	Tax ID #: _____
State License #: _____	National Provider ID #: _____
Practice Name: _____	Street Address: _____
City: _____	State: _____ ZIP Code: _____
Phone #: _____	Fax #: _____

**Patient Information**

Patient Name: _____	Social Security # _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address: _____	City, State, ZIP: _____	
Daytime Phone #: _____	Date of Birth: _____	

**Transplant History**

Transplant Type: _____	Date of Transplant: _____
Transplant Facility: _____	Medicare Approved Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Patient Insurance Information**

Patient has no insurance coverage, including Medicaid or Medicare (Skip to Public Programs Section).

**Primary Insurance Information**

**Secondary Insurance Information**

Payer Name: _____	Payer Name: _____
Policy #: _____ Group #: _____	Policy #: _____ Group #: _____
Payer Phone #: _____	Payer Phone #: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____

**Public Programs (for Patient Assistance Application only)**

Have you applied for Medicaid or other public assistance programs?

**Yes** Program Name: \_\_\_\_\_ Date Applied: \_\_\_\_\_

Status of Application:  Approved  Pending  Denied (If denied, please enclose copy of denial)

**No** Do you intend to apply?  Yes  No If not, why? \_\_\_\_\_

**Financial Information**

Annual Household Income: \_\_\_\_\_ Number of household members dependent on income: \_\_\_\_\_  
 Annual household out-of-pocket medical expenses not reimbursed by insurance (please EXCLUDE costs for Rapamune):  
 Hospital \$ \_\_\_\_\_ Doctor \$ \_\_\_\_\_ Drugs \$ \_\_\_\_\_

**Patient and Physician Declaration**

I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. If Patient is applying for Patient Assistance Program, I certify that Patient is a U.S. resident, and has no government or private insurance to pay for the medication requested, or that paying for the medication from Patient's own resources or assets would cause Patient severe financial hardship. I agree that if this application is approved, the medication will be provided to Patient free of charge, and neither Patient nor any third party will be billed for the medication. I understand that, at any time, Wyeth may modify or discontinue any or all of the Program and related eligibility criteria, or terminate assistance provided by the Program. I have read and understand the Program guidelines and agree to comply with program requirements.

_____ Patient Signature	_____ Date	_____ Physician Signature	_____ Date
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\*Insurance Verification is not a guarantee of payment.

AUTHORIZATION TO USE AND  
DISCLOSE HEALTH INFORMATION

I have requested assistance from the Lash Group, Wyeth and the Wyeth Pharmaceutical Assistance Foundation and their respective employees, representatives, agents or suppliers (collectively "Wyeth") in determining whether my prescription for the prescribed Wyeth product is covered under my current health insurance plan and, if applicable, to determine my eligibility for participation in the Wyeth Patient Assistance Program (the "Program"). I understand that Wyeth needs certain information about me to provide these services. Therefore, I request and authorize my doctor(s) ("Doctor") and my health insurance company(ies) ("Insurer") to give Wyeth, including representatives who work on its behalf, information about my health care treatment and insurance coverage. The type of information that may be given to Wyeth includes information that identifies me, such as my name, address, date of birth, social security number, diagnoses, prior treatments, and information about my health insurance benefits.

I understand that I may decide not to sign this authorization and that my Doctor and my Insurer will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing this authorization. I understand, however, that if I do not sign this authorization I will not be eligible to receive assistance through the Program. However, I understand that if I cancel this authorization, it will not affect prior disclosures made to the program in reliance on this authorization.

I understand that I can cancel this authorization at any time by writing to the Program at the address listed at the bottom of this page. If I cancel this authorization, then my Doctor and Insurer will not provide Wyeth with any further information about me, and the Program will no longer be able to provide me with the assistance I have requested.

I understand that once my Doctor and Insurer give Wyeth information about me based on this authorization, federal privacy laws may not protect my information. I understand that Wyeth is not an entity covered by HIPAA and related federal privacy regulations and that my medical and health information may be subject to redisclosure by Wyeth and no longer protected by such federal privacy regulations. I further understand and agree that Wyeth may retain my medical and health information as disclosed to Wyeth by my Health Care Provider or Insurance under this authorization after this authorization expires for purposes related to the administration of the Wyeth PAP.

I also understand that Wyeth has agreed that it will only use or disclose information provided by my Doctor and Insurer as required or permitted by law and to assist me in determining whether my prescription is covered under my current health insurance plan or for determining my eligibility for participating in the Program or for the administration of the Program. In addition, Wyeth may use and give out my information to refer me to, or to determine my eligibility for, other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my prescription for the prescribed Wyeth product.

**Patient or Personal Representative of Patient**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name (Please Print)**

\_\_\_\_\_  
**Authority to sign on behalf of patient (if applicable)**

**Wyeth Patient Assistance Program  
P.O. Box 220907  
Charlotte, NC 28222-0907**

