Sigma-Tau Patient Assistance Program
4511 Singer Court, Suite 210
Chantilly, VA 20151
Phone: (800) 490-3262
Fax: (866) 694-2544

Program Eligibility:

- The patient cannot have or qualify for any prescription coverage for Abelcet®, DepoCyt® or Oncaspar®, including all federal, state and local programs (such as Medicare, Medicaid, TriCare etc).
- Patient's total annual household income must be at or below 300% of the current Federal Poverty Guidelines (Proof of Income is required – Federal Income Tax Return).

Assistance Available to Eligible Patients

Providers treating eligible patients can receive replacement product to cover outpatient or inpatient treatment administered from the date of program eligibility through 90 days, based on the prescription provided by the physician. A patient being treated as an inpatient or outpatient may apply for retroactive assistance within 45 days of the first treatment date. If eligible, a 90-day supply may be provided from the first treatment date. Re-application is required for assistance over 90-days.

PAP Instructions:

- Please complete the application in its entirety.
- Please have the patient sign the **Patient Statement Section**.
- Please have the practitioner sign the **Practitioner Statement Section**.
- A separate prescription, signed by prescribing physician, must be submitted in addition to the completed application for the drug therapy being requested. Physician orders and treatment records will be accepted for inpatient requests and for outpatient treatment that has taken place within 45 days of application.
- Approved product cannot be shipped without a validated State License Number for the receiving practitioner or facility. Accurate State License Numbers for both the practitioner and the receiving facility are required on the application. Please be advised that if State License Numbers cannot be validated, a copy of the State License or a Letter of Affiliation will be required.
- **Fax the completed application and the prescription** for the brand name product up to a maximum 3-month supply to: **(866) 694-2544.**

sigma-tau PHARMACEUTICALS, INC. Rare dedication

Sigma-Tau PATIENT ASSISTANCE PROGRAM Application

Phone: (800) 490-3262 Fax: (866) 694-2544

PATIENT INFORMATION

Name of Patient

Address

City **State** **Zip**

( ) **Male** **Female**

Phone Number **Gender (circle one)**

Date of Birth **SS#**

1. Does the patient have or qualify for health insurance benefits in any government program? YES ❑ NO ❑
2. Does the patient have or qualify for health insurance benefits in any private program? YES ❑ NO ❑
3. What is the patient's residency status? Permanent Resident ❑ Temporary Resident ❑
4. What is the total **ANNUAL** household income, including social security and pension benefits? $_______________ ANNUAL
5. Household size _______________

INSURANCE INFORMATION

❑ **Check if uninsured**

Primary Insurance

Name Policy # Group #

( )

Phone Number Effective Date

Subscriber's Name Date of Birth

Address

City State Zip

Secondary Insurance

Name Policy # Group #

( )

Phone Number Effective Date

Subscriber's Name Date of Birth

Address

City State Zip

TREATMENT INFORMATION

*****SEPARATE PRESCRIPTION REQUIRED*****

❑ **Abelcet** ❑ **Oncaspar** ❑ **DepoCyt**

Strength **Dose** **Sig.**

Quantity **Length of Therapy**

❑ Inpatient Treatment ❑ Outpatient Treatment

Surgery Date **Discharge Date**

Primary Diagnosis (ICD9 code with description)

Secondary Diagnosis (ICD9 code with description)

Patient Area of Care (Oncology, ICU, CCU, Solid Organ Transplant)

FACILITY INFORMATION

❑ **Shipping Address**

Facility Name **Facility State License #**

Address

City **State** **Zip**

( )

Phone Number **Facility Tax ID#**

Facility Contact *[who we should call concerning this request]*

( ) ( )

Contact Phone Number **Fax Number**

PATIENT STATEMENT

I hereby authorize any insurer, either public or private, employer, hospital, physician, or any other healthcare provider to disclose to Sigma-Tau and its agents, all medical records and information, financial and insurance records and information, as well as other personal identifying information, for the purpose of my participation in the Sigma-Tau Coverage Assistance and Patient Access Program. I also authorize Sigma-Tau and its agents to disclose all such records and information to any of the persons or entities listed above for the purpose of my participation in this program. I understand that any information that reveals my identity will not be used for any purpose other than that described above, unless I give written consent. I verify that the information provided in this application is complete and accurate. I understand that Sigma-Tau reserves the right at any time and without notice to modify the application or modify or discontinue this program and the related eligibility criteria. I authorize Sigma-Tau to use my Social Security number for identification purposes and record keeping only. I have read, understand and agree to all of the above.

Patient's Signature **Date**

PRESCRIBER INFORMATION

❑ **Shipping Address**

Name **Specialty**

Address

City **State** **Zip**

( ) ( )

Phone Number **Fax Number**

DEA# **Professional Designation (MD, DO, etc)**

Prescriber State License # **Tax ID #**

( )

Office Contact Name **Contact Phone Number**

PRESCRIBER STATEMENT

I represent that the information contained in this application is complete and accurate and, to the best of my knowledge, this patient has no prescription insurance coverage, including all public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I understand that Sigma-Tau reserves the right to modify or terminate this program at any time. My signature certifies that these goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I understand that Sigma-Tau reserves the right to recall the product when necessary.

Licensed Prescriber's Signature (Required) **Date**