

WinRho SDF[Rh₀(D) Immune Globulin Intravenous (Human)]

WinRho Plus Reimbursement Support and Patient Assistance Program
 PO Box 230906
 Centreville, VA 20120
 Phone: (800) 4WINRHO Fax: (800) 643-9450

INSTRUCTIONS: Please complete the below application and return via mail or facsimile, to the WinRho Plus Reimbursement Support and Patient Assistance Program

SECTION ONE: PATIENT INFORMATION

First Name: _____ MI _____ Last Name: _____
 SSN: _____ DOB: _____ Phone: _____
 Address: _____ Apt # _____
 City: _____ State: _____ Zip Code: _____

SECTION TWO: PATIENT FINANCIAL INFORMATION

Annual Household gross income: \$ _____
 Annual Household Out of Pocket Medical Expenses: \$ _____
 Number of dependents within household (including applicant): _____
 Note: Proof of Income such as W-2 form, previous year tax return, or 3 consecutive pay stubs is required.

SECTION THREE: DISTRIBUTION INFORMATION

Number of 500 mcg/2500 IU vials needed for one month supply: _____
 Shipping Address, if different than address given in Section Six below:
 Site/Clinic Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

SECTION FOUR: PATIENT INSURANCE INFORMATION

Primary Insurance Company Name: _____ Policy Number: _____
 Telephone # _____ Policy Holder Name and DOB: _____
 Sec/Supplement Insurance Company Name: _____ Policy Number: _____
 Telephone # _____ Policy Holder Name and DOB: _____
 Any other type of insurance coverage, such as Medicaid or other public assistance programs? Y/N
 If so, please provide the name(s) of the programs: _____
 Has coverage for Medicaid ever been denied? Y/N Denial reason: _____

SECTION FIVE: PATIENT CONSENT AND AUTHORIZATION

I certify that all of the above statements and any information provided are correct and that I understand eligibility under this program are subject to Baxter Healthcare's approval. I grant Baxter or its agents the right, at all times, to investigate any and all claims made under this program. I agree that Baxter Healthcare, or its representatives, and/or any organization selected by Baxter Healthcare to represent it, may see, or get a copy of, all medical, prescribed drug, and insurance coverage records from my healthcare provider or my insurance company which pertain to treatment with Baxter Healthcare's product for:

 Print patient's name

This information is for the sole use of Baxter Healthcare and/or its representatives. Unless required by law, information will not be given in an identifiable form to any persons unless the patient agrees to its release in writing. This authorization will become effective when signed below and will remain in effect until revoked in writing by the patient. A photocopy of this form is valid as the original.

 Signature of Patient or Legal Representative

NOTE: Baxter reserves the right to limit or modify in whole or in part the Patient Assistance Program, specific to any patient or provider, or terminate the program, at any time without further notification. In addition, no patient will be accepted into the program without the provider's and patient's (or legal representative's) original signature on this form. Baxter reserves the right to make separate, independent determination of patient eligibility.

SECTION SIX: PROVIDER INFORMATION

Physician Name: _____ State License # _____

Site/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Physician Certification: I understand that I agree to follow this patient through his/her entire course of Winrho SDF. I understand that I will be sent Winrho SDF once I have provided all requested documentation in a timely manner to Baxter or its agents regarding therapy with Baxter products for this patient.

Physician Signature_____
Date

Financial Eligibility Statement

For Patients Currently Enrolled in a Baxter
Insurance Gap Program

Baxter Patient Assistance Programs
P.O. Box 230906
Centreville, VA 20120
Fax: (800) 643-9450

Patient Name:		Social Security Number:	
Street Address:			Date of Birth: / /
City:	State:	Zip:	Phone: ()
Sources of Income: (Gross Annual)			
Salary/ Wages	\$ _____	Social Security	\$ _____
Social Security Disability	\$ _____	Pension/ Retirement	\$ _____
Child Support/ Alimony	\$ _____	Unemployment/ Workman's Comp	\$ _____
Total Gross Annual Income: \$		Number in Household (including self):	
<i>Please submit documentation to support income information. Acceptable documents include any of the following:</i>			
◆ U.S. Income Tax Return	◆ W-2 Statement	◆ Social Security Benefit Statement	◆ Pay Stub
◆ IRS Form 1040			
◆ Disability Statement			
<p>■ I understand that the information provided above is being used solely to determine my eligibility for product assistance through Baxter's Insurance Assistance programs and will not be shared with any other third party, nor with Baxter for any reason.</p> <p>■ I certify that, by submission of this form, I do not have health insurance coverage from any public or private entity, nor am I receiving any state funded assistance to support the cost of my medication. I understand that at such time that I obtain prescription coverage or have the financial resources to pay for the cost of my therapy, I will notify Baxter's Patient Assistance program administrator of such a change in my coverage status.</p> <p>■ I certify that the information I have provided on this form is complete and accurate to the best of my knowledge. I also certify that I do not have sufficient financial resources to pay for the medication requested, or that paying for these medications from my own resources would cause me financial hardship.</p> <p>■ I understand that Baxter reserves the right to modify or cancel the Patient Assistance programs at any time.</p>			
_____ <i>Patient or Guardian Signature</i>		_____ <i>Date</i>	

If you have any questions about Baxter's Patient Assistance Programs, call 1-888-229-8379.



WINRHO PLUSSM Program

WinRho Distribution Request Form

Complete one form for each patient enrolled in the WinRho PlusSM Program. Sections A-D must be completed along with a prescription. Please fax completed form and prescription to 800-643-9450.

Date submitted: _____

A. Patient Information Requesting Product

Baxter customer number: _____

Provider name: _____

Contact person: _____

Contact phone number: _____

B. Patient Information

Patient name: _____ Date of Birth: _____

Patient dose (units/month): _____ Patient weight (kg): _____

C. Product Requested

Product: _____ Total Number of Units: _____

On demand request for: 30 days of therapy

D. Insurance Status

Please indicate the current status of obtaining insurance coverage or public funding for factor concentrate:
(If medical assistance was denied, denial letter is required)

CERTIFICATION STATEMENT

I certify that the product shipped by Baxter Healthcare Corporation under this Program will be given to the patient indicated, free of charge. No third party or patient will be charged for the free units, and no free units will be distributed for sale to any individuals. In addition, I represent that the information contained in this form is complete and accurate to the best of my knowledge and agree to notify the WinRho PlusSM Program administrator of any changes I become aware of that would affect the eligibility status of the patient. I also understand that the product may not be the identical potencies requested for distribution to the patient and that, further, Baxter will make every effort to ship the exact number of units documented on this form to the nearest clinical requirement. Finally, I certify that the patient receiving this free product from Baxter has attempted to obtain insurance coverage for WINRHO SDF but that at this time the patient does not have and is not eligible for any public or private health insurance.

Provider's signature: _____ Date: _____

Title: _____ Phone number: _____

Physician name: _____

Physician address: _____

If you have any questions about the WinRho PlusSM Program, please call 888-229-8379 or Fax 800.643.9450