

**Wyeth Factor Resource Program™ Enrollment Form**

Please complete this form to the fullest extent possible and fax the completed form to the Wyeth Factor Resource Program at 866-559-9640. This form may be used to inquire regarding your patient's coverage for BeneFIX® Coagulation Factor IX (Recombinant), ReFacto® Antihemophilic Factor (Recombinant) or Xyntha™ Antihemophilic Factor (Recombinant), enroll in the Insurance Coverage Program or to apply to the Patient Assistance Program. If you have any questions, please call 1-888-999-2349.

Requested services:  Insurance Verification\*  Patient Assistance Program

**Wyeth Factor Resource Program**  
**PO Box 220907 Charlotte NC 28222-0907**  
**Phone: 888-999-2349, Fax: 866-559-9640**

**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 : _____
Address: _____	City, State, ZIP: _____
Daytime Phone #: (____) _____	Email Address: _____ Date of Birth: _____

**Product Utilization Information**

Therapy: <input type="checkbox"/> BeneFIX <input type="checkbox"/> ReFacto <input type="checkbox"/> Xyntha	Patient Diagnosis: _____
Initial Therapy Start Date: _____	Previous Year Factor Utilization (in IU): _____

**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 (gross): \_\_\_\_\_ Number of household members dependent on income: \_\_\_\_\_

**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, and 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 I will not submit a claim for reimbursement to or collect reimbursement from patient or any third party for the medication. Patient has provided a valid HIPPA authorization for to Physician pertaining specifically to the Program, which Physician maintains. Patient authorizes Wyeth and its agents to utilize personal information to administer Patient's participation in the Program 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**

\*Insurance Verification is not a guarantee of payment.

**Wyeth Factor Resource Program™  
Provider Prescription Form**

Please complete this form to the fullest extent possible and fax the completed form to the Wyeth Factor Resource Program at 1-866-559-9640. This form is required for patients approved for product assistance before the initial shipment can be sent. The prescribing physician's signature is required.

**Wyeth Factor Resource Program  
PO Box 220907 Charlotte NC 28222-0907  
Phone: 888-999-2349, Fax: 866-559-9640**

**Physician Information**

Physician Name: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ State License #: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
 Shipping Address (if different from above): \_\_\_\_\_  
 Shipping City, State, ZIP: \_\_\_\_\_  
 Daytime Phone #: (\_\_\_\_) \_\_\_\_\_ Evening/Other Phone #: \_\_\_\_\_

**Prescribing Information (Must be completed in its entirety)**

**BeneFIX® Coagulation Factor IX (Recombinant)**

Vial Sizes: #\_\_\_\_ 250 IU #\_\_\_\_ 500 IU  
 #\_\_\_\_ 1000 IU #\_\_\_\_ 2000 IU

Monthly dosage = \_\_\_\_\_ IU

SIG: **As directed** Number of Refills: \_\_\_\_\_

\_\_\_\_\_  
 Patient allergies

\_\_\_\_\_  
 Physician Signature

**Please circle either ReFacto or Xyntha below:  
 ReFacto® Antihemophilic Factor (Recombinant)  
 Xyntha™ Antihemophilic Factor (Recombinant)**

Vial Sizes: #\_\_\_\_ 250 IU #\_\_\_\_ 500 IU  
 #\_\_\_\_ 1000 IU #\_\_\_\_ 2000 IU

Monthly dosage = \_\_\_\_\_ IU

SIG: **As directed** Number of Refills: \_\_\_\_\_

\_\_\_\_\_  
 Patient allergies

\_\_\_\_\_  
 Physician Signature

I have prescribed BeneFIX, ReFacto or Xyntha for the above patient. My patient gave consent for me to provide this information. I will not submit a claim for reimbursement to or collect reimbursement from any third party or patient for BeneFIX, ReFacto or Xyntha provided by this program. I understand that no free product should be sold or distributed for sale.

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date

**Program Use Only**

To: Distribution Agent

The Wyeth Factor Resource Program authorizes the award of BeneFIX, ReFacto or Xyntha ("Product") to the patient listed above. Subject to the prescriber's authorization and the patient's continued use of the Product, please dispense the Product to the patient in the quantities listed above.

*The Wyeth Factor Resource Program ("Program") reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. The Program may amend the number of refills based on program limits, extenuating circumstances or special exceptions.*

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**