



**TORISEL™ Reimbursement
Support Program**
PO Box 220907
Charlotte NC 28222-0907
Phone: (866) 993-8466
Fax : (866) 993-8411

November 12, 2008

Thank you for your recent interest in the TORISEL Reimbursement Support Program. Our program is designed to provide complimentary services to those providers and patients who are using or are interested in using TORISEL™ (tamsirolimus). Our services include both reimbursement support and patient assistance. We are available Monday through Friday, 9 a.m. to 6 p.m. eastern time.

The reimbursement support services are designed to ease the reimbursement process and assist providers with a wide range of services, including

- Benefit verifications, to research your patient's coverage for TORISEL
- Coding assistance, to provide recommended coding to support claim submission
- Claims assistance, to review claims accuracy and completeness
- Claims tracking assistance, to follow up on the status of submitted claims through payer determination
- Claim denial assistance, including denial reason and researching the appeals process
- Payer policy investigation, to provide information about coverage and payment policies for TORISEL
- Alternate insurance research, to assist patients in finding adequate coverage for TORISEL

The TORISEL Reimbursement Support Program also offers patient assistance and product replacement support for patients who lack adequate coverage for TORISEL and meet the specific eligibility criteria for these program services. To request reimbursement support, patient assistance, or product replacement assistance for TORISEL, please complete, sign, and fax the enclosed enrollment form to the TORISEL Reimbursement Support Program at (866) 993-8411.

You may also call (866) 993-8466 to initiate the enrollment process or to obtain additional information regarding available support services for TORISEL.

Sincerely,

A handwritten signature in black ink that reads "Michelle Buynak". The signature is written in a cursive, flowing style.

Michelle Buynak
Regional Reimbursement Consultant



**TORISEL™ (temsirolimus) Reimbursement Support and Patient Assistance Programs
Physician Enrollment Form**

Please complete this form and fax to the TORISEL Reimbursement Support and Patient Assistance Programs at 1-866-993-8411. Your completion of this form will facilitate future program requests. To inquire regarding your patient's coverage for Torisel, or to apply for the TORISEL Patient Assistance Program, please submit a completed Patient Enrollment and Application Form.

**TORISEL Reimbursement Support and Patient Assistance Program
PO Box 220907 Charlotte NC 28222-0907
Phone: 866-993-8466 Fax: 866-993-8411**

Physician Information

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

**Shipping Address/Infusion Site
(If different from above)**

Physician Declaration

By signing below, I agree on my behalf and on behalf of the facility referenced above to the following:

- I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. I have read and understand the Program guidelines and agree to comply with program requirements. 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 understand that medication provided under the Patient Assistance Program is provided free of charge to eligible patients.
- I understand that I may seek replacement for TORISEL that has been administered to a patient who then has his or her insurance claim denied after an appeal. If the patient met the other eligibility criteria for the Patient Assistance Program at the time the medication was administered, the product the patient received may be replaced. I understand that product replacement may be available only for fully denied, not underpaid claims, and excludes any procedure, service or other cost related to the administration of the drug. I understand that documentation of insurance denial and appeal are required, and I agree to provide such documentation.
- I certify I will not charge any patient or any third party for medication provided under the Patient Assistance Program, including medication that is replaced.
- I understand that if a patient's insurance status changes, the patient may no longer be eligible under the Program and I agree to immediately notify the Program if I become aware of changes in the patient's insurance status.
- I agree that if retroactive insurer policy change or decision provides reimbursement for free medication provided or replaced, I will immediately notify the Program and the Program will bill for the medication or arrange for billing.
- I understand that I am under no obligation to prescribe any drug and that I have not received nor will I receive any benefit from Wyeth for prescribing any Wyeth drug.
- I understand that the Program is not responsible for filing any insurance claims and provides no guarantee of payment.
- I agree to abide by this certification throughout my participation in the Program and notify immediately a Program representative if any aspects of my certification are no longer applicable.

Physician Signature

Date



TORISEL™ (temsirolimus) Reimbursement Support and Patient Assistance Programs
 PO Box 220907, Charlotte NC 28222-0907
 Phone: 866-993-8466 Fax: 866-993-8411
Patient Enrollment and Application Form

All items must be completed. This form may be used to inquire regarding Patient's coverage for TORISEL, or to apply for the Patient Assistance Program. Please be sure to include both patient and physician signatures below.

Requested services: Insurance Verification* Patient Assistance Program

Physician Information

Physician Name: _____ Site Name: _____

Select One: Physician Office Hospital Outpatient Hospital Inpatient Other

Practice Address: _____ City, State, ZIP: _____

Contact Name: _____ Phone #: _____ Fax #: _____

Treatment Information TORISEL™ (temsirolimus)

Dosage: _____ Treatment Start Date: _____

Product Shipping Address/Infusion Site (If different from above) _____

Patient Information

Patient Name: _____ Social Security #: _____ Male Female

Address: _____ City, State, ZIP: _____

Daytime Phone #: (____) _____ Date of Birth: _____

Patient Insurance Information

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

Primary Insurance Information (including Medicaid or Medicare)

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

Have you applied for Medicaid, Medicare 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.

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**