core Comprehensive Oncology Reimbursement Expertise

ENROLLMENT FORM

PLEASE FAX COMPLETED FORM TO **866-676-4073**

FOR QUESTIONS, CALL **888-587-3263** BETWEEN THE HOURS OF 9AM AND 6PM ET

Patient

1 PATIENT INFORMATION

First Name (First MI Last)		Social Security #:
DOB (mm/dd/yyyy)	Phone	
Address		
City	State	ZIP
Contact Name (if other than patient)	Contact Phone	
Permanent U.S. Resident? ☐ Yes ☐ No	Gender: ☐ Male ☐ Female	

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2 FINANACIAL AND INSURANCE INFORMATION

Annual Gross Household Income (before taxes) $

Attach copies of proof of income for you and all dependent persons in the household
Example: Federal income tax)form 1040, 1040EZ, 1099, 1099-DIV, or 1099-I or yearly benefits statement (SSA, 1099, or award)

# of Household Members Dependent on Income Stated
(To include you, your spouse, and dependents)

PLEASE INCLUDE COPY OF INSURANCE CARDS, FRONT AND BACK AND ENLARGED*

Medicare Coverage ☐ Yes ☐ No ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage	Medicare Policy # Effective Date:

If PART D or Medicare Advantage, list Prescription Drug Plan information below

	Insurance Name	Phone	ID/Policy #	Group #
Primary				
Secondary				
State Program				
Veteran or Other Plan				

Medicaid ☐ Not applied ☐ Denied ☐ Pending	Veteran ☐ Yes ☐ No	Applied for VA? ☐ Yes ☐ No

3 PATIENT AUTHORIZATION

I certify that the information I have provided is truthful and accurate to the best of my knowledge. I understand that any assistance provided to me through the CORE Program (the "Program") is contingent upon my ability to meet the eligibility criteria for the Program as determined by Teva Pharmaceuticals USA, Inc. and that my application for assistance does not guarantee acceptance into the Program. Any assistance for which I may be eligible will only be awarded after my documentation has been received and approved by the Program. In the event that I am eligible for the Program, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Program. Assistance is not guaranteed for any specific time frame and may be terminated at any time for any reason without any notice to me. I agree that I will notify the Program within thirty (30) days if my insurance or financial situation changes as this may impact my eligibility to participate in the Program. I certify that I have not received and will not seek to receive reimbursement for the Teva drug requested and/or supplied through the Program. I agree that the Program and its affiliates, agents and representatives shall not be liable for any damages, of any kind, without limitation, in connection with my receiving Product assistance, benefits, or services provided by the Program. I have read, understand and agree to all of the above.

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Patient Name	
Signature ✕	Date ✕
*If signed by someone other than the patient, describe legal authority to do so:	
Personal Representative Name (if applicable)	Signature

I authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions, and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare provider directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research, and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 7588, Overland Park, KS 66207, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

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Patient Signature ✕	Date ✕
If signed by someone other than the patient, describe legal authority to do so:	

*We will contact you if additional documentation is required

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Healthcare Professional

1 PHYSICIAN INFORMATION

Physician Name	DEA #	NPI #
Medical License #	MD Tax ID #	
Facility Name	Group Tax ID #	
Address		
City	State	ZIP
Medicaid Provider # and Pin:	PTAN #:	
Clinical Contact:	Contact Title:	
Contact Phone:	Contact Fax:	
Billing Contact:	Contact Title:	
Contact Phone:	Contact Fax:	

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2 PRESCRIBING INFORMATION

Patient Name (First MI Last)	Date of Birth
Site of Care	Is patent being treated outpatient ☐ Yes ☐ No
Patient Primary Diagnosis – ICD-10 Code	Description
Patient Secondary Diagnosis – IDC-10 Code	Description
Clinical History/Failed Therapies	

Choose Drug Name:

☐ SYNRIBO® (omacetaxine mepesuccinate) Injection, for subcutaneous use ☐ TRISENOX® (arsenic trioxide) injection
☐ BENDEKA® (bendamustine hydrochloride) injection ☐ TREANDA® (bendamustine hydrochloride) for Injection
☐ GRANIX® (tbo-filgrastim) Injection

Therapy GIVEN			Therapy PLANNED for month		
Date(s)	Dose	Frequency	Date(s)	Dose	Frequency

3 PHYSICIAN DISTRIBUTION AND SIGNATURE

If shipping address is the same as the mailing address above, please confirm by checking the box. ☐ If not, please indicate shipping address below

Shipping Address

City State ZIP

On behalf of my patient, I request assistance for the oncology drug manufactured by Teva Pharmaceuticals ("Teva") specified in this application. I attest that the information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed the drug specified in this application based on my professional judgment of medical necessity. I understand that the patient must meet financial parameters to be eligible under the program. I certify that I have not received, and will not seek to receive, reimbursement for any drug requested, replaced and/or supplied under the Comprehensive Oncology Reimbursement Expertise (CORE) Program. I certify that no free product provided under this Program will be distributed for sale to any individual or organization or returned for credit. I understand that if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge, Teva will bill me for the covered product, and I agree to be responsible for payment of the bill. If I submit a claim to patient's insurance company for services rendered in conjunction with the administration of a product provided under this program, I agree to fully disclose to the insurance company that the product was provided free of charge under this Program. I agree to abide by this certification throughout any participation in the Program and to notify a Program representative if aspects of my certification are no longer applicable. I understand that if the patient's income or insurance status changes, the patient may no longer be eligible under this Program. I agree to immediately notify a Program representative if I become aware that the patient's insurance or income status changes, or if a retroactive insurer policy change allows for reimbursement of product already supplied at no charge. I understand that Teva reserves the right to modify or terminate this Program at any time without prior notice and reserves the right to recall the product when necessary. I understand that I am under no obligation to prescribe any Teva drug to participate in this Program and that I have not received, nor will I receive any benefit from Teva or its agents, for prescribing a Teva drug. I understand that Teva and its agents are not responsible for filing any insurance claim. PAP: I understand that in a number of circumstances, as described in CORE Program supporting material, I will be required to appeal the denial from patient's insurance company before receiving any product under this program. I agree to become familiar with these requirements and certify that in circumstances where an appeal is required : (i) I will submit a claim to the patient's insurance company; and (ii) if the claim is denied I will submit an appeal to the patient's insurance company, prior to requesting free product under this Program. If product is provided by Teva under this Program, I will return to patient any deductibles or co-insurance made by patient for the product.

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Physician Signature ✕	Date ✕

teva