

FAX

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| TO: | FROM: |
| FAX: | PAGE(S): |
| RE: | DATE: |
| CASE: | PRODUCT: |

Thank you for your interest in the Comprehensive Oncology Reimbursement Expertise (CORE) Program. The CORE Program is a confidential service sponsored by Teva Oncology that supports physicians and patients in determining reimbursement for PRODUCT®.

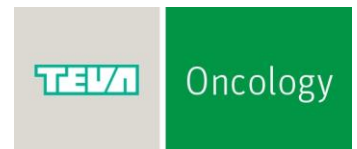
To ensure your CORE Enrollment Form is processed accurately, please:

1. Complete patient demographics, insurance, and patient financial information
 - Financial information is used to help identify alternative coverage options which may have financial eligibility guidelines
2. Obtain the signature of the patient/legal guardian
3. Complete physician demographics and treatment/therapy information
 - Treatment/therapy information is used to help verify insurance benefits. Prescribing decisions are at the sole discretion of the physician
4. Obtain the original signature of the physician
5. Please provide copies of insurance cards (front & back) and enlarge if available
6. For expedited service, please fax the completed CORE Enrollment Form to **1-866-676-4073**
7. Or mail the completed form to:

The CORE Program
6900 College Boulevard, Ste. 1000
Overland Park, KS 66211

If you have any questions please call me at 1-888-587-3263, extension USER PHONE. We are available to answer your call Monday through Friday, from 9:00 am to 8:00 pm Eastern Time (excluding holidays).

Thank you.



The documents accompanying this fax transmission may contain information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this fax in error, please notify the sender at 913-663-3969.

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| <i>For Internal Use Only</i> | Case #: | Date: | <input type="checkbox"/> RS <input type="checkbox"/> PAP |
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Comprehensive Oncology Reimbursement Expertise (CORE) ENROLLMENT FORM

6900 College Boulevard, Suite 1000 ♦ Overland Park, KS 66211
Phone: 888-587-3263 ♦ Fax: 866-676-4073
Between the hours of 9 AM and 8 PM (ET)

PATIENT INFORMATION: (Please type or print clearly)

Patient Name (First MI Last): _____

Social Security #: _____ **Date of Birth:** _____

Street Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Contact Name (if other than patient): _____ **Contact Phone:** _____

US Citizen/Legal Resident? YES NO **Gender:** Male Female

FINANCIAL INFORMATION: (Please complete with a dollar amount. Please do NOT leave blank or put N/A.)

Annual Gross Household Income (Before Taxes): _____ **# of household members dependent on income stated:** _____

Attach copies of proof of income for you and all dependent persons in the household. To include you, your spouse and dependents

Example: Federal income tax (form 1040, 1040EZ, 1099, 1099-DIV, or 1099-I) or yearly benefits statement (SSA, 1099, or award).

INSURANCE INFORMATION: (Please list all policies and provide copies of cards, front and back.)

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

Does the patient have Medicare Coverage: YES NO **Check all that apply:** Part A Part B
 Part D Medicare Advantage

Medicare Policy #: _____ **Effective Date:** _____

If has 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: | | | | |

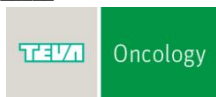
MEDICAID: Not applied Denied Pending **VETERAN?** YES NO **Applied for VA?** YES NO

I verify that the information provided in this application is current, complete, and accurate. I authorize my healthcare providers, insurance companies, employers, and other sources as deemed necessary to disclose to Teva Oncology and its agents and assignees, all medical records and information, financial and insurance records and information, as well as other personal identifying information, with respect to myself, for the purpose of my enrollment or participation in the Comprehensive Oncology Reimbursement Expertise (CORE) Program. I also authorize Teva Oncology and its agents or assignees to disclose all such records and information, whether provided by myself or any third party, for the purpose of my enrollment or participation in the CORE Program. I understand that any such records or information that reveals my identity will not be used for any purpose other than that described above unless I have given written consent. I understand that any assistance provided to me by Teva Oncology through the CORE Program is contingent upon my ability to meet the eligibility criteria and that completing the enrollment process does not guarantee acceptance into the CORE Program. I also understand that Teva Oncology reserves the right at any time and without notice to modify the application form or modify or discontinue this Program and the related eligibility criteria. I authorize Teva Oncology to use my Social Security number for identification purposes and record keeping. I agree to notify the CORE Program within thirty (30) days if there is any change in the status of my eligibility to receive products through this Program. I certify that I have not received, and will not seek to receive, reimbursement for the Teva Oncology drug requested and/or supplied under the CORE Program. I have read, understand and agree to all of the above. This consent is valid until rescinded in writing and a photocopy or faxed copy may be used in place of the original.

Patient/Legal Guardian* Signature: _____ **Date:** _____

* Please provide a description of the Legal Guardian's authority to act for the patient.

Please Fax Completed Form to 866-676-4073



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Phone: 888-587-3263 ♦ Fax: 866-676-4073
Between the hours of 9 AM and 8 PM (ET)

PHYSICIAN INFORMATION: (Please type or print clearly)

Physician Name: _____ DEA #: _____

NPI #: _____ Medical License #: _____ MD Tax ID #: _____

Facility Name: _____ GroupTax ID #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Medicaid Provider # and Pin: _____ PTAN#: _____

Clinical Contact: _____ Contact Title: _____

Contact Phone: _____ Ext: _____ Contact Fax: _____

Billing Contact: _____ Contact Title: _____

Contact Phone: _____ Ext: _____ Contact Fax: _____

PRESCRIBING INFORMATION:

| | | | | | |
|--|--------------|------------|-----------------------------------|-------|------------|
| Patient Primary Diagnosis – ICD-9 Code: | Description: | | | | |
| Patient Secondary Diagnosis – ICD-9 Code: | Description: | | | | |
| Clinical History/Failed Therapies: | | | | | |
| Choose Drug Name: <input type="checkbox"/> TREANDA® (bendamustine HCl) for injection <input type="checkbox"/> TRISENOX® (arsenic trioxide) injection | | | | | |
| Therapy GIVEN: | | | Therapy PLANNED for month: | | |
| Date(s): | Dose: | Frequency: | Date(s): | Dose: | Frequency: |
| | | | | | |
| | | | | | |

DISTRIBUTION:

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 Is Same As Mailing Address

Shipping Address: _____

City: _____ State: _____ Zip: _____

On behalf of my patient, I request assistance for the Teva Oncology drug 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 Oncology will bill you 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 Oncology 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 Oncology drug to participate in this Program and that I have not received, nor will I receive any benefit from Teva Oncology or its agents, for prescribing a Teva Oncology drug. I understand that Teva Oncology 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 Oncology under this Program, I will return to patient any deductibles or co-insurance made by patient for the product.

Physician Signature: _____ Date: _____

Please Fax Completed Form to 866-676-4073

