EUSAPharma

FAX or EMAIL

To:	From:
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Re:	Date:
Case:	Product::

Instructions for Community Access Patient Program (CAPP) Confidential Application Form:

Reimbursement Revenue Solutions, LLC has been retained by EUSA Pharma to review CAPP Applications and determine a patient's benefits and if they have available resources to purchase prescribed medication. Reimbursement support will be provided for Caphosol including benefit investigations, prior authorization, and appeals assistance. CAPP will determine if the patient is eligible for co-pay assistance or free product, if they have no insurance.

The CAPP Co-Pay Assistance Program is designed for patients with health insurance where payer co-pays or co-insurance is in excess of $50/prescription of up to 8 Week packs. If eligible, they will receive Caphosol for a total cost of $50/prescription of up to 8 Week packs. Eligible patients will have the product shipped directly to their home from Avella Specialty Pharmacy at no additional charge.

The CAPP Patient Assistance Program (PAP) eligibility is based on the patient's inability to access medication due to no insurance coverage including disqualification from government programs, and whose total family income is at or below 200% of the Federal Poverty Level as defined by the Department of Health and Human Services (HHS) in their Annual Update on the HHS Poverty Guidelines found at http://aspe.hhs.gov/poverty/. Any denials for assistance may be reviewed by asking for an eligibility appeal.

CAPP also has counselors available to investigate alternative coverage, such as co-pay assistance or premium assistance foundations, State or Federal sponsored programs, or other forms of assistance that might be available.

To ensure your application is processed accurately, please be sure that:
- ☑ All sections of the application are complete
- ☑ The patient and physician have signed and dated the Application Form
- ☑ The physician's NPI is included on the form in the field indicated if you wish CAPP to investigate these benefits on the patient's behalf.
- ☑ **If you are seeking assistance with free product, please include a copy of the facility or physician's state license for shipping purposes.**
- ☑ **If you are seeking assistance with free product, please include proof of income of the patient as listed on the application. Proof of income includes:** Copy of Federal tax return, W-2, copy of month's worth of recent paystubs, copy of Social Security check or awards letter, etc.

PLEASE FAX COMPLETED FORM TO: 888-653-8006 OR EMAILTO CAPP@EUSAPHARMA.COM
Community Access Patient Program reserves the right to change eligibility guidelines, terminate, or modify this program at any time for any reason.

Community Access Patient Program (CAPP)

1 Tara Blvd., Suite 200
Nashua, NH 03062
Phone: 888-688-EUSA ◆ **Fax:** 888-653-8006
CAPP@eusapharma.com

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Please note that incomplete applications cannot be processed and will be returned to you.

Any denials for assistance may be reviewed by asking for an eligibility appeal. Please contact your CAPP Representative with any questions at **888-688-EUSA (3872).** Operating Hours are **Monday – Friday 9:00 AM – 5:00 PM EST**

Please be advised that EUSA Pharma reserves the right to discontinue the program at any time for any reason. We may also choose to limit the period of medication assistance and also the quantities given.

PATIENT NAME: **CASE #:**

Physician Name   **DEA #**

NPI #   **Medical License**

Facility Name   **Tax ID #**

Address (No PO Boxes)

City   **State**   **Zip**

Clinic Contact   **Contact Title**

Contact Phone   **Ext**   **Secure Fax**

Prescribing Information (Please print or type)

Patient Diagnosis (ICD-10)   **ICD-10 Description**

Therapy is being provided in: ☐ **Physician's Office**   ☐ **Hospital Outpatient Facility**

Is doctor contracted with patient's insurance?   ☐   **YES**   ☐   **NO**

Product Requested:	Dose:	Frequency:	Quantity:	Treatment Date(s) GIVEN	Treatment Date(s) PLANNED
☐ **CAPHOSOL**			**# 30 Dose Dispensing Week Pack:**		

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**

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Physician / Prescriber Attestation

I certify that the product subject to this application is medically necessary for the patient for the drug's labeled indication and that the information stated herein, as well as the documentation furnished in support of this application, is accurate to the best of my knowledge. If the patient is enrolling in the Patient Assistance Program, I certify that to the best of my knowledge and upon due diligence, the patient referenced above is unable to afford the medication and does not have, or qualify for, coverage under any Federal healthcare program, including Medicare and Medicaid. I acknowledge my responsibility for receiving any product, storing it separately, and providing it for the outpatient treatment of this patient only.

Original Signature of Licensed Practitioner (no stamps accepted) _____ Date_____

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Patient Name _____   **Date of Birth** _____

Phone _____   **Gender** ☐ **Male**   ☐ **Female**

Social Security Number _____   **US Resident?**   ☐ **Yes**   ☐ **No**

Address _____

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

Alt. Contact Name/Phone _____   **Relationship to Patient** _____

Number of people in your household? _____   (to include you, your spouse, legal guardians, and dependents)

Annual gross family income (before taxes) $ _____   To include salary, pension, unemployment or worker's comp, Social Security, disability, alimony, child support, interest/dividends, rental property, etc.

Do you have any health insurance coverage?   ☐ **Yes**   ☐ **No**

What type of insurance coverage do you have? (Check all that apply)

> **Provide copies of all insurance cards enlarged, front and back**

☐ Medicare Part A   ☐ Medicare Part B   ☐ Medicare Part D   ☐ Medicare Advantage   ☐ Medicaid   ☐ Veterans

☐ State Program   ☐ Employer   ☐ Other _____ (Please fill in name of Insurer)

For each policy you have, please attach a copy of both sides of your insurance card complete following:

Primary Insurance _____   Secondary Insurance _____

Phone Number _____   Phone Number _____

Policy ID _____   Policy ID _____

Group # _____   Group # _____

Policy Holder _____   Policy Holder _____

Have you recently received a Denial Letter for this product?   ☐ Yes   ☐ No
→ If Yes, please attach the denial letter.
Have you applied to Medicaid?   ☐ Not applied   ☐ Pending   ☐ Denied
Are you a Veteran?   ☐ Yes   ☐ No   **→ If Yes, have you applied for VA benefits?**   ☐ Not applied   ☐ Pending   ☐ Denied

I understand that EUSA Pharma's and the Community Access Patient Program (CAPP) and its agents will treat this information confidentially in accordance with their privacy policies. I authorize, which authorization shall remain in effect for one year from the date hereof, that my provider and any health insurance plan, may disclose to EUSA Pharma's Community Access Patient Program (CAPP), and/or their representatives, information about my medical condition, treatment, and insurance coverage (for example, my diagnosis, medical history, and insurance coverage limitations) as needed to evaluate and determine eligibility for coverage under the terms of my health insurance policy or potential coverage options. Further, I consent to being contacted by EUSA Pharma CAPP with respect to supporting the benefit investigation process. I verify that the information provided in this form is complete and accurate. I understand that EUSA Pharma CAPP reserves the right at any time, and without notice, to modify the application forms, change eligibility guidelines or otherwise terminate or modify the program at any time or any reason. I authorize EUSA Pharma and its agents to obtain information from prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this form.

Patient/Guardian Signature _____ Date_____