



Patient Assistance & Support Enrollment Form

2730 S. Edmonds Lane, Suite 300
Lewisville, TX 75067

Benefit Investigation Co-Pay Assistance PAP
Please check one or more services being requested

Phone: 855.215.2720 Fax: 855.341.3943

Patient Information

First Name:		M.I.:	Last Name:	
Address:				
City:		State:	Zip Code:	
Home Phone:		Cell Phone:		
SSN:	DOB: / /	US Resident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Provide Financial details only if applying for PAP -		Number of dependents in household (including self): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> _____		
Annual Household Income: \$	Attached is: <input type="checkbox"/> A copy of most recent Federal Tax Return <input type="checkbox"/> Other Supporting Financial Documents			

Patient Insurance Information- Please attach copies of cards for primary and secondary insurance plans

Insurance Name:		Phone:
ID/Policy #:	Policy Holder Name:	
Group #:	Secondary Plan?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder DOB: / /
Plan Type: <input type="checkbox"/> Private <input type="checkbox"/> Medicare Part A/B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicaid <input type="checkbox"/> VA or Military <input type="checkbox"/> I do not have insurance coverage		

Diagnosis and Procedure Information

Primary Diagnosis Code Category: <input type="checkbox"/> C15- Malignant Neoplasm of Esophagus <input type="checkbox"/> C34- Malignant Neoplasm of Bronchus and Lung	
Additional / Other ICD-10-CM Code(s):	
Additional / Other ICD-10-CM Descriptions:	
<input type="checkbox"/> J9600- Photofrin® (porfimer sodium) for injection, 75 mg <small>(Confirmation of product & J-Code can assist with benefit verification and authorization process)</small>	Administration CPT Code(s): <input type="checkbox"/> 96374 <input type="checkbox"/> 96409 <input type="checkbox"/> 96413 <small>(Check all that apply- Provide Procedure CPT code information in treatment & procedure history area below)</small>
Procedure CPT Code(s): <input type="checkbox"/> 43229 Esophagoscopy <input type="checkbox"/> 43270 Esophagogastroduodenoscopy <input type="checkbox"/> 31641 Bronchoscopy <input type="checkbox"/> Other: _____	

Patient Authorization and Agreement

By signing this authorization, I authorize my health care providers, physicians, health plans, specialty distribution center, third party service provider (collectively "providers") to use, share and disclose my personal protected health information (PHI), including, but not limited to, information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form. My PHI will be given to Pinnacle Biologics, Inc ("Pinnacle"), its vendor Sonexus Health, and its representatives, agents and contractors that help with the management of the Patient Assistance & Support Program (the "Program") to: (1) establish my eligibility for benefits and evaluate my eligibility for any applicable assistance programs that will aid in receiving my treatment; (2) facilitate the provision of products, supplies or services by a third party including, but not limited to specialty distributors; (3) and to contact me with educational or treatment support materials and requests for participation in patient programs related to treatment.

My signature certifies that I have read and understand- (1) The above statements regarding the release of my PHI to the Photofrin® Patient Assistance & Support Program including its use and disclosure purposes; (2) I may refuse to sign this authorization and that my treatment, payment, enrollment or eligibility for benefits is not conditioned on my signing this authorization (3) I can cancel or revoke this authorization at any time by writing to the Program address above; (4) I understand that, if approved for the Program, Pinnacle will send the medication to my physician listed below for my treatment; (5) I understand that Program eligibility is subject to Pinnacle's discretion and Pinnacle reserves the right to modify or terminate the Program at any time; (6) I hereby release and forever discharge Pinnacle and its vendor Cardinal Health, Inc. from any and all liability related to the Program; and (7) The information provided in this application is current, complete, and accurate.

Patient Signature _____ Date _____

Physician Information

Physician Name:		Physician NPI #:	
Physician License #:	Physician Group Tax ID #:		
Practice Name:			
Address:			
City:		State:	Zip Code:
Office Contact Name:	Phone #:	Fax #:	
Office Contact Email Address:			

Physician Certification: My signature certifies that (1) I am duly licensed and authorized under applicable law to prescribe, receive and dispense the medication requested in this application to the patient listed above (the "Patient"); (2) The information provided above is complete and accurate; (3) I understand the Program eligibility is subject to Pinnacle's discretion and Pinnacle reserves the right to modify or terminate the Program at any time; **If patient applying to Patient Assistance Program-** (4) I have prescribed the requested medication for the Patient and the medication shall be used for the sole purpose of treating the Patient for an indication that is consistent with the FDA Approved label use of PHOTOFRIN®; (5) I understand that, if the Patient is approved for the Program, the requested medication shall be sent to my office for dispensing to the Patient; (6) The medication will not be offered for sale, trade or barter; (7) I shall not seek reimbursement from any source for the requested medication or a related office visit, including the Patient or any private or public health care program or third party payor; and (8) I consent to an on-site audit of any information related to the Program

Physician Signature _____ Date _____
(original signature required)



Please see Important Safety Information and full US Prescribing Information at www.photofrin.com.

