PDT with **PHOTOFRIN®**
TARGETING ~~CANCER~~ MARGINS
(porfimer sodium) for injection

Patient Assistance & Support Enrollment Form

☐ Benefit Investigation ☐ Co-Pay Assistance ☐ PAP

Please check one or more services being requested

2801 Lakeside Dr., Suite 210
Bannockburn, IL 60015
Phone: 224.795.8308 **Fax:** 847.557.2010

Patient Information

First Name:	M.I.:	Last Name:	
Address:			
City:		State:	Zip Code:
Home Phone:		Cell Phone:	
SSN:	DOB: / /	US Resident: Yes ☐ No ☐	Gender: Male ☐ Female ☐

Provide Financial details only if applying for PAP- Number of dependents in household (*including self*): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ ____

Annual Household Income: $	Attached is: ☐ A copy of most recent Federal Tax Return ☐ 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?: ☐ Yes ☐ No	Policy Holder DOB: / /

Plan Type: ☐ Private ☐ Medicare Part A/B ☐ Medicare Advantage ☐ Medicaid ☐ VA or Military ☐ I do not have insurance coverage

Diagnosis and Procedure Information

Primary Diagnosis Code Category:

ESOPHAGUS
☐ **C15**- Malignant Neoplasm of Esophagus

LUNG
☐ **C34-** Malignant Neoplasm of Bronchus and Lung

BILE DUCT
☐ **C24**- Malignant Neoplasm of Extrahepatic Bile Duct
☐ **C22.1**- Intrahepatic Bile Duct Carcinoma

Additional / Other ICD-10-CM Code(s):

☐ **J9600- PHOTOFRIN®** (*porfimer sodium*) for injection, 75 mg *(Confirmation of product & J-Code can assist with benefit verification and authorization process)*	**Administration CPT Code(s):** ☐ 96374 ☐ 96409 *(Check all that apply- Provide Procedure CPT code information in treatment & procedure history area below)*

Procedure CPT Code(s): ☐ _____

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 Pathfinders Medical Business Solutions, LLC, 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.

I may revoke this authorization in writing at any time. I understand my revocation will not affect any disclosures that were made by my providers before receipt of my written revocation. If I do not revoke it, this authorization will expire upon completion of the benefit investigation and/or PAP approval process.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

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 of eligibility for benefits under my health plan is not conditioned on my signing this authorization but that if I refuse to sign this authorization I will not be eligible for Program services and applicable assistance programs.; **(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 Pathfinders Medical Business Solutions, LLC from any and all liability related to the Program; and **(7)** The information provided in this application is current, complete, and accurate.

Patient or Personal Representative of the Patient _____ **Date** _____

(Relationship to Patient) _____

Physician Information

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

Dosage: Patient wt _____ x 2 mg/kg = _____ mg **Quantity:** _____ x 75 mg vials

Ship To: ☐ Prescriber's Office ☐ Other _____

(If Other, please include full mailing address information)

Directions: _____

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 for Patient Assistance- (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 3rd 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.

PINNACLE BIOLOGICS