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BENDEKA® (bendamustine HCl) injection

ENROLLMENT FORM

PLEASE FAX COMPLETED FORM TO **866-676-4073**
FOR QUESTIONS, CALL **888-587-3263**

Patient

Requested Services: ☐ Benefits Verification ☐ Prior Authorization Support ☐ Claims Support ☐ Appeals Support ☐ Independent Patient Assistance Foundations Information

1 PATIENT INFORMATION (PATIENT TO COMPLETE SECTIONS 1-3)

First Name (First MI Last):		
DOB (mm/dd/yyyy):	Phone:	
Address:		
City:	State:	ZIP:
Contact Name (if other than patient):	Contact Phone:	
Permanent U.S. Resident?: ☐ Yes ☐ No	Preferred Language: ☐ English ☐ Spanish ☐ Other	Gender: ☐ Male ☐ Female ☐ Unspecified

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2 INSURANCE INFORMATION

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

Medicare Coverage: ☐ 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

Any other government sponsored plan? ☐ Yes ☐ No

3 PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE(S)

PATIENT AUTHORIZATION

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 7613, 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 a nd 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:	

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Healthcare Professional

1 PHYSICIAN INFORMATION (PHYSICIAN TO COMPLETE SECTIONS 1-3)

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: ☐ Physician Office ☐ Facility/Hospital	Is patient being treated outpatient?: ☐ Yes ☐ No
Patient Primary Diagnosis — ICD-10 Code: Description:	
Patient Secondary Diagnosis — IDC-10 Code: Description:	

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

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Physician Signature: ✕	Date: ✕

3 PRESCRIBER SIGNATURE

After discussing the Program for my prescribed medication and/or medical condition (including its agents, service providers, and dispensing pharmacies) with the patient, the patient has elected to participate in the Program. I authorize the release of medical and/or other patient information relating to therapy to this Program, Teva Pharmaceuticals USA, Inc., its affiliates and its designated agents and service providers (collectively, "Teva"), to use and disclose as needed for fulfillment of the prescription related to this Program, and furnish any information in this form to the insurer of the above-named patient. I understand that Teva reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva. ****STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY.**

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Physician Signature: ✕	Date: ✕