INSURANCE BENEFIT VERIFICATION FORM

PROCRITline™ 1-800-553-3851

PROCRIT® (Epoetin alfa)
LEUSTATIN® (cladribine) Injection

Mail to: PROCRITline P.O. Box 220247 Charlotte, NC 28222-0247 Fax: 1-800-987-5572

Is this patient on dialysis? If yes, do not complete this form. Call PROCRITline at 1-800-553-3851

Please print and mail or fax along with patient authorization.

Verify Benefits For: PROCRIT _____ LEUSTATIN _____

PATIENT INFORMATION

Patient Name

Name of Guardian (if appropriate)

Patient Address

City State Zip

Phone Number--Home Work

Social Security Number Date of Birth

M_____ F_____

Can we contact the patient directly? Yes _____ No_____

INSURANCE INFORMATION

Name of Insurance Co. Policy Number Group Number

(_____)
Phone Number Provider ID # For Insurance

Subscriber's Name Date of Birth

Subscriber's Relationship to Patient

Secondary Insurance Co. Policy Number Group Number

(_____)
Phone Number Provider ID # For Insurance

Subscriber's Name Date of Birth

Subscriber's Relationship to Patient

PHYSICIAN INFORMATION

Name of Facility

Name of Physician Specialty

Address

City State Zip

Phone Number Fax Number

Office Contact Phone Number

National Provider Identification (NPI) Number ______________________

Provider Tax ID Number ______________________

DRUG THERAPY

Verify Benefits For:: PROCRIT ___ LEUSTATIN ___

Patient Diagnosis:____

ICD-9 Code/s:____

FOR PROCRIT ONLY:

Has patient started PROCRIT therapy? Yes____ No ____
If Yes, start date:__________
Initial HCT:_____________ Initial HGB:_____________

For cancer patients, is the patient on chemotherapy? Yes____ No ____

For nephrology patients, what is the patient's:
Serum Creatinine __________ Creatinine Clearance__________

Is the patient taking PROCRIT pre-operatively? Yes_____ No _____
If Yes, what type of surgery? _________________

Authorization to Share Health Information for Reimbursement Services

Provider Instructions: Patients must complete this form before they can participate in the Program.

I, ___________________________, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for Procrit® (Epoetin alfa) or Leustatin® (cladribine) to The Lash Group, Inc., Ortho Biotech, Centocor, Inc., and Centocor Ortho Biotech Services, LLC (the "Companies"). The Lash Group, Inc. runs the Reimbursement Program (the "Program") for Ortho Biotech Products, L.P., the marketer of Procrit and the maker Leustatin.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

The Companies may use and give out my information solely in connection with the Program, to see if I qualify for the program, run the Program, or as otherwise as required or allowed under law. People who work for and with the Companies may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

I understand that the Companies may contact me by telephone, postal mail or email (if I provided an email address) in connection with my enrollment in the Program and this authorization. This Authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with the Companies, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to the Companies.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Sign Here: ____ Date: _______________________

Patient Name: ____

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: ___________________________________

By: ___________________________________
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:

____

A copy of this form must be provided to the patient.