Insurance Verification Request Form

How can Helsinn Cares HELP YOU?

☐ **Benefits Investigation** ☐ **Appeals Assistance**

☐ **Prior Authorization**

Please complete all fields with black ink and fax form to 1-844-357-4669.
For help, please call 1-84-HELSINN-U (1-844-357-4668).

Patient Information

Name: (First) _____ (Last) _____

DOB: (mm/dd/yyyy) ____/____/____ Gender: ○ Male ○ Female

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____

Email: _____

Preferred Language: ○ English ○ Spanish ○ Other: _____

Preferred Contact Method (If Available): ○ Phone ○ Email ○ Text Message

If you are unavailable when we call, may we leave a message including the prescription name? ○ Yes ○ No

Comments: _____

_____

Prescriber Information

Prescriber Name: (First) _____ (Last) _____

State License #: _____ NPI # : _____

Prescriber Phone: (_____)_____-_____

Name of Facility: _____

Facility Street Address: _____

City: _____ State: _____ ZIP Code: _____

Office Contact Name: (First) _____ (Last) _____

Title/Position: _____

Office Contact Phone: (_____)_____-_____ Fax: (_____)_____-_____

Preferred Contact Method (If Available): ○ Phone ○ Fax ○ Email ○ Text

Email: _____

Place of Service (check all to be verified)

☐ Physician Office (11) ☐ Hospital Inpatient (21) ☐ Hospital Outpatient Department (22)

☐ Skilled Nursing Facility (31) ☐ Other (please specify): _____

Insurance Information

Please complete all that apply and include front and back copy of Insurance card for each type of Insurance

☐ Patient has no insurance ☐ Medicaid ☐ VA/DOD ☐ Medicare (Part A Part B Part D Medicare Advantage)

Primary medical insurance: _____ Policy ID#: _____

Insurance telephone number: _____ Group #: _____

Policy holder name (First, Last): _____

Relationship to patient: _____ Date of birth: _____

Secondary medical insurance: _____ Policy ID#: _____

Insurance telephone number: _____ Group #: _____

Policy holder name (First, Last): _____

Relationship to patient: _____ Date of birth: _____

Prescription / Pharmacy Drug Plan Name: _____ Phone number: _____

Policy ID#: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____

Patient Clinical Information

ICD-10-CM (nausea/vomiting related): _____ _____

Names of Prior Antiemetics _____

Current Chemotherapy Class: _____

Prescription Information

☐ **AKYNZEO® (300mg netupitant/0.5mg palonosetron) capsule**

Dosing Instructions: _____

_____

Start Date: ____/____/____ Refills: _____ Number of Capsules: _____

☐ **AKYNZEO® (235mg fosnetupitant/ 0.25mg palonosetron) injection**

Chemotherapy Regimen: _____

_____

Start Date: ____/____/____ Number of Cycles: _____ Every _____ Days

PATIENT NAME [FIRST, MI, LAST]:	DATE OF BIRTH:

Patient Authorization For Use/Disclosure of Health Information

I understand that I am submitting this application to Mercalis, or my doctor's office is submitting it on my behalf, to see if I qualify for financial assistance and other services to help me find possible sources of financial assistance, or to assess whether I have insurance coverage for Akynzeo® (netupitant/palonosetron) capsule. I understand that before you can assist me, you may need to collect, use, and disclose information about me that is requested on this application, including my Protected Health Information ("PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 as amended ("HIPAA")), my financial information and other personal information about me (collectively "My Personal Information"). PHI that will be disclosed includes any information related to my healthcare insurance or plan benefits, including coverage limits and other information related to my health.

I understand that by signing this form, I am permitting my doctor's office, my healthcare plan or insurance company, my pharmacies, as well as other entities that may hold my PHI, to release My Personal Information, including my PHI, to Mercalis and to Mercalis agents who may be assisting with the administration of the patient assistance programs. I understand that to provide the support for the patient assistance programs, and the Mercalis agents may need to further disclose My Personal Information to and communicate with other Mercalis agents involved with patient assistance programs, my doctor's office or other health care providers, including my insurance company or health plan or pharmacies.

I further understand that Mercalis and the Mercalis agents will use My Personal Information in the following manner: (1) to review my application for patient assistance programs; (2) to help determine my healthcare plan coverage for Akynzeo and other procedures as part of my therapy by conducting reimbursement verification and obtaining payment from my Health Plan(s); (3) to contact me or my doctor's office or other of my health care providers, as necessary, to conduct such services; and (4) providing me with educational support services by mail, text, messaging, email and/or telephone and (5) referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the cost of Aknyzeo.

I understand that I do not have to sign this consent, but if I do not, Helsinn Cares cannot provide the described assistance. I understand that I might need to pay for Akynzeo on my own, whether I sign this form or not. I understand that once my doctors, healthcare plan, pharmacies, or others who have my Protected Health Information release it, my information may no longer be covered by Federal Privacy Law (for example, HIPAA).

This authorization allows those who rely on it to release my Protected Health Information for 10 years from the date I have signed it. I understand that I can withdraw it at any time by sending a written request to the mailing address below. My withdrawal goes into effect once it is received by the program. I also understand that by withdrawing, I may not receive or I may stop receiving the services provided under this program.

Patient's Signature:_____ Date of Signature: _____/_____/_____

Printed Name: _____

Parent/Guardian/Legal Representative's Signature: _____ Date of Signature: _____/_____/_____

Printed Name: _____ Relationship to Patient: _____

Patient Authorization To Disclose To Others

In order to protect your privacy we will not share your information with anyone you do not authorize. Please list names of anyone you would like to have access to your medical information. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize Mercalis, its staff and providers to disclose my protected health information to the following representative:

Name: _____ Phone Number: (_____)_____–_____

Relationship to Patient: _____

Patient's Signature:_____ Date of Signature: _____/_____/_____

Prescriber Attestation

By signing below, I verify that the information provided in this Helsinn Cares Patient Support Program Form is complete and accurate to the best of my knowledge. I understand that Helsinn reserves the right at any time and for any reason, without notice, to modify this Helsinn Cares Patient Support Program Form or to modify or discontinue any assistance provided through Helsinn Cares Patient Support Program. Finally, I authorize Mercalis to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement assistance through Helsinn Cares Patient Support Program and (as applicable) to assess my patient's eligibility for copay assistance. My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Mercalis for purposes of the Helsinn Cares Patient Support Program.

Prescriber's Signature:_____ Date of Signature: _____/_____/_____

Mail us at
Patient Support
2250 Perimeter Park Drive
Suite 300
Morrisville, NC 27560

Call us at
1-84-HELSINN-U
Monday - Friday, 8 AM - 8 PM ET

Fax us at
1-844-357-4669