

**DOXIL<sup>®</sup>** (doxorubicin HCl liposome injection)  
**PATIENT ASSISTANCE PROGRAM**  
**ELIGIBILITY APPLICATION FORM**  
**Telephone 1- 800-609-1083**

COPIES OF THIS FORM ARE AVAILABLE AT  
[WWW.DOXILINE.COM](http://WWW.DOXILINE.COM).  
**Mail or fax this completed form to:**  
**DOXILine, P.O. Box 1016, San Bruno, CA 94066**  
**Fax 1-800-987-5572**

<b>Patient Information</b> (Please Print Clearly)			
New Application Yes <input type="checkbox"/> No <input type="checkbox"/>		Renewal Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Patient _____		M <input type="checkbox"/>	F <input type="checkbox"/>
Name of Guardian (if appropriate) _____			
Patient's Address _____		City _____	State _____ Zip _____
Phone Number – Home _____		Phone Number – Work _____	
Date of Birth _____		Social Security Number _____	

Does this patient have insurance coverage for DOXIL?  Yes  No

Has patient applied to public programs such as Medicaid or state drug assistance program?  Yes  No

If Yes, date applied \_\_\_\_\_

If yes, to which programs? \_\_\_\_\_

**Financial Qualification for Program**

I have \$0 income. \_\_\_\_\_ (check if applicable)

Gross Annual Household Income and Source of Income

Salary/Wages/Unemployment	\$ _____
Pension/Social Security	\$ _____
SSI	\$ _____
SSDI	\$ _____
Other	\$ _____
_____	\$ _____
Total	\$ _____

Number of household members dependent on income stated above (include applicant) \_\_\_\_\_

**Proof of Income Documentation**

Attached is a copy of my most recent federal tax return. (X)	<input type="checkbox"/>
I do not file federal taxes. (X)	<input type="checkbox"/>

**Applicant Declaration.** "I promise that the information on this form is correct and complete. If needed, Ortho Biotech Products, L.P. and its Patient Assistance Program (the "Program") may request and obtain information about my, or my family's income to enroll me in the Program. I understand that the Program administrators reserve the right any time and without notice to modify the application form; modify or discontinue any or all of the program and the related eligibility criteria; or terminate assistance provided by the program at any time."

Please indicate your agreement with these terms by signing below.

\_\_\_\_\_ Date \_\_\_\_\_

Patient Signature or Authorized Representative

If Representative, please explain relationship \_\_\_\_\_

<b>Provider Information</b> (Please Print Clearly)		
Name of Physician _____		
Practice or Facility Name _____		
Address		
Line 1 _____		
Line 2 _____		
City _____	State _____	Zip _____
Office Phone Number _____		
Office Fax Number _____		
Office Contact Name _____		
Office Contact Telephone _____		

<b>Prescription Information</b>		
Name of Drug <b>DOXIL<sup>®</sup></b> (doxorubicin HCl liposome injection) _____		
Dose _____	Sig _____	Quantity _____
Expected Duration of Therapy (months) _____		
<b>Physician Signature</b> _____		
Physician State License Number _____		

**Distribution Option:**

**Direct Shipment Instructions**

Please provide special shipping instructions for product shipped directly to physician office or hospital facility (i.e. office hours available for delivery)

\_\_\_\_\_

\_\_\_\_\_

**Physician Declaration**

To the best of my knowledge, this patient does not have prescription drug coverage (including Medicaid, county funded assistance, or other public programs) for DOXIL. The DOXIL Patient Assistance Program requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product or administration of product provided under the program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

\_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS FORM MAY NOT BE ALTERED IN ANY WAY**

**Authorization to Share Health Information for Reimbursement  
or Patient Assistance Programs 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), Doxil® (doxorubicin HCl liposome injection) Leustatin® (cladribine), or Orthovisc® (High Molecular Weight Hyaluronan) to Lash Group. Lash Group runs the Reimbursement and Patient Assistance Programs (the "Programs") for Ortho Biotech Products, L.P., the marketer of Procrit and Orthovisc, and the maker of Doxil, and 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.

Lash Group and Ortho Biotech will use and give out this information to see if I qualify for the Programs and to run the Programs. People who work for and with Lash Group and Ortho Biotech 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.

This Authorization will last until I am no longer participating in the Programs. 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 Lash Group or Ortho Biotech, 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 Lash Group and Ortho Biotech.

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 Programs.

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.