LeukineDirect®
PATIENT ASSISTANCE PROGRAM
APPLICATION

PTx PARTNER THERAPEUTICS®

LeukineDirect Reimbursement Hotline
PO Box 4133, Gaithersburg, MD 20855-4133
Phone: 877-3LEUKINE (877-353-8546) **Fax:** 855-881-6864
Hours: Monday through Friday, 9:00 am – 5:00 pm Eastern Time

APPLICATION CHECKLIST (Application will be delayed if all information is not received)

- ☐ Provider AND Patient signature required
- ☐ All information in required fields
- ☐ Proof of Income (includes, but not limited to: 1040 form, Social Security Retirement and Supplemental Social Security Income, SSA 1099 from previous year, Unemployment award letter)

PRESCRIBER INFORMATION (required)

Physician Name:		Specialty:	
Physician Address:	City:	State:	Zip:
Physician Tax ID# :		Physician NPI#:	
Physician State License#:	Issuing State:	DEA# :	

FACILITY INFORMATION (required)

Facility Name :	Facility NPI:	Facility Tax ID #:	
Facility Address:			
City:	State:	Zip Code:	

Facility Setting: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Home Infusion ☐ Other – Please specify:

Contact Name:	Contact Email:	
Contact Phone #:	(Extension)	Contact Fax #:

PREFERRED METHOD OF CONTACT

What is your preferred method to receive program communication? ☐ Fax ☐ Email (If checked, please provide email address:_____
Please note: All communication is sent via fax if this is not checked

PATIENT INFORMATION (required)

Patient Name:	Date of Birth:	SSN/ID# (last 4 digits):	
Phone#:	US Resident? ☐ Yes ☐ No	Gender ☐ M ☐ F	
Patient Address:	City:	State :	Zip Code:

PATIENT INSURANCE INFORMATION (Attach a copy of insurance cards, if available). CHECK HERE IF UNINSURED ☐

Primary Insurance:	Policy#:	Group #:
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:
Secondary Insurance:	Policy#:	Group #:
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:

PRESCRIPTION INFORMATION (required)

Drug: Leukine® (sargramostim) 250 mcg vial	**Quantity:** Indicate Number of Cartons per Month (1 Carton = 5 vials)	**Refills:**	**ICD 10 Diagnosis:**
SIG:			
Height: **Weight:**	**Allergies:**		

X_____
Prescribing Clinician's original signature (no stamped signatures)

_____
Date

PRESCRIBING CLINICIAN CERTIFICATION AND CONSENT (required)

By signing below, I am certifying that the information contained in this form is complete and accurate to the best of my knowledge. My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive, and administer the requested medication(s) listed on this application form. I understand that Partner Therapeutics, Inc. reserves the right to modify or terminate LeukineDirect at any time and without notice. I understand that Partner Therapeutics is not responsible for filing claims and that the information provided by LeukineDirect is advisory in nature. All final decisions on diagnosis, the need for treatment, and the appropriateness of Leukine® (sargramostim) for a particular patient rest with me as the patient's provider. I understand that I am under no obligation to prescribe any Partner Therapeutics drug and I have not received and will not receive any benefit from Partner Therapeutics for prescribing a Partner Therapeutics drug. I further verify that I have the required authorizations, including a valid and completed HIPAA Authorization form, from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to LeukineDirect. If my patient participates in the Patient Assistance Program, I certify that I will not charge the patient or submit a claim to any third party for services related to my patient's Leukine therapy. I understand that any product provided under the Patient Assistance Program must only be used for the approved patient and may not be sold, traded, or returned for credit.

Prescribing Clinician Name (print):

Prescribing Clinician Signature (no stamped signatures): Date:

PATIENT ASSISTANCE (certification and authorization to disclose information) (required)

Patient Name: Date of Birth:

Patient's Total Annual Household Income: $ Household Size (including patient):
(Attach the most current copies of income documentation for you and all dependent persons. See list of documents below in the Application Checklist Section.)

Ship to Name:

Ship to Facility Name (if applicable):

Ship to Address:

City: State: Zip Code:

Ship to Contact Phone Number: (Extension)

I understand that LeukineDirect ("the Program") is a patient support program that offers eligible patients services relating to benefits verification, claims support, prior authorization/appeals assistance and medication costs. By filling out this form, I am submitting an application for the Program's Patient Assistance Program, which helps eligible patients with the costs of Leukine. I attest that the information in this application is true, correct, and complete, and understand that any assistance offered by the Program will terminate if the Program becomes aware of any fraud or if Leukine ® (sargramostim) is no longer prescribed to me. I agree to update the Program should any of the information on this application form change, including if I become eligible for any benefit through a federal, state, or private program, which may reimburse for Leukine® (sargramostim). I understand that changes in my health insurance coverage may impact my eligibility for the Program. I also understand that in order for the Program to provide me with assistance, it will need to obtain, review, use, and disclose information related to my personal health, including information related to my medications, medical conditions and the personal and financial information on my application form.By signing this form, I authorize my treating doctor, my employer, and my health insurer to give people who work for and with Partner Therapeutics, including its business partners and agents ("Partner Therapeutics"), information about my insurance and my health. Partner Therapeutics may use my information to help verify or coordinate insurance coverage or to obtain payment or other support for mytreatment. In carrying out these activities, Partner Therapeutics may share information about me with my doctor, my employer, my health insurer, and independent third-party patient assistance foundations. Third parties may receive payment from Partner Therapeutics to provide the services associated with the Program.I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy. I understand that my consent lasts for one (1) year from the date that I am approved into the Program. I understand that Partner Therapeutics has the right to change or end the Program at any time without prior notification to me. I understand that I may refuse to sign this form and that doing so will not affect my doctor's treatment of me or my eligibility for insurance benefits. I further understand that I may revoke this Authorization at any time by contacting the Program in writing that includes my name, date of birth, address and date of revocation. The revocation will not apply to any information already used or disclosed pursuant to this Authorization. I understand if I do not sign, refuse to sign, or cancel my authorization, I will not be eligible for the Program. I give consent to my physician or facility to receive medication on my behalf to be administered to me as prescribed. I permit Partner Therapeutics, Inc. to speak with the Patient Representative named below about the information on this application and the status of my application request. This includes discussing insurance and financial questions, any missing documentation and other issues related to my application.

Patient Name (print): Date of Birth:

Patient Signature: 

Date:

Patient Representative Name (print): Relationship to Patient:

Patient Representative Signature: Date:

PATIENT ASSISTANCE PROGRAM DISCLAIMER: Partners Therapeutics reserves the right to request additional documentation to confirm eligibility.

 March/2022 (version # 0.2)