FastAccess | Exeltis
Rethinking healthcare

Foundation Care Contact Information:
Phone: 877.303.7181 • Fax: 877.620.2849

FastAccess Program ("Program") Confidential Application Form

Foundation Care has been retained by Exeltis to review Program applications and determine a patient's benefits and if they have available resources to purchase prescribed medication. Reimbursement support will be provided for Benznidazole Tablets including benefit investigations, prior authorization, and appeals assistance. Foundation Care will determine if the patient is eligible for co-pay assistance or product at no charge, if they have no insurance or are underinsured.

The physician must fill out Sections 1 through 4 below. The patient must fill out Section A through D below. Both the physician and patient must sign where indicated.

1. Physician Stamp Here

Preferred Contact: ❑ Email ❑ Phone

2. Prescription

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Program), medication will be shipped via a specialty pharmacy.

Patient Name: _____ Patient Date of Birth: ____/____/_____

Product Name: _____

Strength: ❑ 100 mg ❑ 12.5 mg

Directions: _____

Refill(s): _____ Quantity: _____

Physician Signature: _____ / _____ Date: _____
(Substitutions Permitted) (Dispense as Written)

Prescriber Name: _____ NPI #: _____ License #: _____
(Please Print)

Note: New York State prescribers must submit a state-approved prescription with this complete form.

3. Patient Clinical Information

Patient Diagnosis/*ICD-10* Code:

B57. _____ Other: _____

B57. _____ Other: _____

A. Patient Information

Patient Name: _____ Primary Language: _____ Date of Birth: _____

Shipping Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Best Time to Call: _____

Email Address: _____

Please fax to 877.620.2849

B. Patient Insurance Information

Primary Rx Insurer (BIN/PCN): _____ Telephone: _____

Policy ID Number: _____ Rx Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Secondary Rx Insurer (BIN/PCN): _____ Telephone: _____

Policy ID Number: _____ Rx Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Check here if Patient has no insurance: ❑

Please include a photocopy of the patient's insurance card(s), if possible.

C. Patient Financial Information*

Current annual household income: $ _____

Number of household members dependent on income state above (include applicant): _____

*If you would like to be considered for co-pay or product support, please provide income information for potential eligibility determination. If approved for support, Exeltis reserves the right to request documentation (latest tax return, W2, or 1 month of pay stubs).

D. Patient Authorization for the Program

I understand my healthcare provider has authorized the Program to perform the specified reimbursement support services on my behalf. I authorize my healthcare providers (e.g., physician, pharmacist) and my insurance company to disclose personal health information about me to Foundation Care, Exeltis, the Program, and their agents. Foundation Care, Exeltis, the Program, and their agents may contact me and use and release information about me only for the purposes of (i) assisting in my enrollment in the Program; (ii) performing the reimbursement support services specified herein; (iii) assessing my eligibility for co-pay assistance or free drug; and (iv) coordinating delivery of Benznidazole Tablets to my healthcare provider. I understand that some of my information may be provided anonymously and used in an individual or aggregated form for other legitimate purposes by Exeltis. I understand that reasonable efforts will be made to keep my information private even though some of my information which is re-disclosed under this authorization may no longer be protected under federal and state privacy laws.

Any co-pay assistance or drug furnished at no charge provided to me through the Program is contingent upon meeting certain eligibility criteria, and Exeltis may, at any time, and without notice, modify or discontinue the Program or any assistance provided directly to me.

I understand that I do not have to sign this authorization to obtain treatment or seek payment for treatment on my own; however, in order to be eligible for the services provided by the Program, I must sign the authorization. I understand that I may cancel my authorization, or opt out of receiving any of the above services or communications, at any time by contacting the Program at 877-303-7181, by fax at 877-620-2849, or by mail at 4010 Wedgeway Court, Earth City, MO 63045. If I cancel the full authorization, then my healthcare providers and my insurance company will not provide any further information about me, and the Program will no longer be able to provide me with the assistance, education, or services described above.

I verify that the information provided in this enrollment form is current, complete, and accurate.

This authorization expires in ten (10) years.

By signing, I agree that I have read and agree to the authorization above:

Patient Signature: _____ Date: _____

Legal Guardian or Representative Signature: _____ Date: _____

Relationship to Patient: _____

4. Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Benznidazole Tablets based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's HIPAA authorization on file to disclose his/her health information and to transfer such authorization to Foundation Care and Exeltis and their agents to use and disclose such information as necessary to provide reimbursement services and to forward this prescription to a dispensing pharmacy on behalf of my patient.

If checked below, as applicable, I authorize the Program to perform: (a) benefits investigation; (b) prior authorization; and (c) if needed, appeals support. I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required for all checked items.

❑ Benefits Investigation ❑ Prior Authorization ❑ Appeal Support

Physician Signature: _____ Date: _____

Email: FastAccess@Exeltis.com
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The physician must fill out Sections 1 through 4 below. The patient must fill out Sections A through D on the second page. Both the physician and the patient must sign where indicated.

1. Physician Information

Physician Name: _____ Site/Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Telephone: _____ Best Time to Call: _____

Office Contact Email: _____ Fax: _____ **Preferred Contact:** ❑ Email ❑ Phone

Tax ID #: _____ NPI #: _____ License #: _____

2. Prescription

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Program), medication will be shipped via a specialty pharmacy.

Prescriber Name: _____

Patient Name: _____ Patient Date of Birth: ____/____/_____

Product Name: _____

Strength: ❑ 100 mg ❑ 12.5 mg

Directions: _____

Refill(s): _____ Quantity: _____

Physician Signature: _____ / _____ Date: _____
(Substitutions Permitted) (Dispense as Written)

Note: New York State prescribers must submit a state-approved prescription with this complete form.

3. Patient Clinical Information

Patient Diagnosis/*ICD-10* Code:

B57. _____ Other: _____

B57. _____ Other: _____

A. Patient Information

Patient Name: _____ Primary Language: _____

Shipping Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Best Time to Call: _____

Email Address: _____

Email: FastAccess@Exeltis.com
Please fax to 877.620.2849

B. Patient Insurance Information

Primary Rx Insurer (BIN/PCN): _____ Telephone: _____

Policy ID Number: _____ Rx Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Secondary Rx Insurer (BIN/PCN): _____ Telephone: _____

Policy ID Number: _____ Rx Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Check here if Patient has no insurance: ❑

Please include a photocopy of the patient's insurance card(s), if possible.

C. Patient Financial Information*

Current annual household income: $ _____

Number of household members dependent on income state above (include applicant): _____

*If you would like to be considered for co-pay or product support, please provide income information for potential eligibility determination. If approved for support, Exeltis reserves the right to request documentation (latest tax return, W2, or 1 month of pay stubs).

D. Patient Authorization for the Program

I understand my healthcare provider has authorized the Program to perform the specified reimbursement support services on my behalf. I authorize my healthcare providers (e.g., physician, pharmacist) and my insurance company to disclose personal health information about me to Foundation Care, Exeltis, the Program, and their agents. Foundation Care, Exeltis, the Program, and their agents may contact me and use and release information about me only for the purposes of (i) assisting in my enrollment in the Program; (ii) performing the reimbursement support services specified herein; (iii) assessing my eligibility for co-pay assistance or free drug; and (iv) coordinating delivery of Benznidazole Tablets to my healthcare provider. I understand that some of my information may be provided anonymously and used in an individual or aggregated form for other legitimate purposes by Exeltis. I understand that reasonable efforts will be made to keep my information private even though some of my information which is re-disclosed under this authorization may no longer be protected under federal and state privacy laws.

Any co-pay assistance or drug furnished at no charge provided to me through the Program is contingent upon meeting certain eligibility criteria, and Exeltis may, at any time, and without notice, modify or discontinue the Program or any assistance provided directly to me.

I understand that I do not have to sign this authorization to obtain treatment or seek payment for treatment on my own; however, in order to be eligible for the services provided by the Program, I must sign the authorization. I understand that I may cancel my authorization, or opt out of receiving any of the above services or communications, at any time by contacting the Program at 877-303-7181, by fax at 877-620-2849, or by mail at 4010 Wedgeway Court, Earth City, MO 63045. If I cancel the full authorization, then my healthcare providers and my insurance company will not provide any further information about me, and the Program will no longer be able to provide me with the assistance, education, or services described above.

I verify that the information provided in this enrollment form is current, complete, and accurate.

This authorization expires in ten (10) years.

By signing, I agree that I have read and agree to the authorization above:

Patient Signature: _____ Date: _____

Legal Guardian or Representative Signature: _____ Date: _____

Relationship to Patient: _____

4. Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Benznidazole Tablets based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's HIPAA authorization on file to disclose his/her health information and to transfer such authorization to Foundation Care and Exeltis and their agents to use and disclose such information as necessary to provide reimbursement services and to forward this prescription to a dispensing pharmacy on behalf of my patient.

If checked below, as applicable, I authorize the Program to perform: (a) benefits investigation; (b) prior authorization; and (c) if needed, appeals support. I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required for all checked items.

❑ Benefits Investigation ❑ Prior Authorization ❑ Appeal Support

Physician Signature: _____ Date: _____

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Foundation Care has been retained by Exeltis to review Program applications and determine if patients have available resources to purchase prescribed medication. For patients without insurance and are presumed indigent, Benznidazole Tablets shall be provided at no charge from Exeltis' Patient Assistance Plan (PAP).

The physician must fill out Sections 1 through 4 below and sign where indicated.

1. Physician Stamp Here

Preferred Contact: ❑ Email ❑ Phone

2. Prescription

Upon approval for assistance through the Program, medication will be shipped via a specialty pharmacy.

Patient Name: _____ Patient Date of Birth: ____/____/_____

Product Name: _____

Strength: ❑ 100 mg ❑ 12.5 mg

Directions: _____

Refill(s): _____ Quantity: _____

Physician Signature: _____ / _____ Date: _____

(Substitutions Permitted) (Dispense as Written)

Prescriber Name: _____ NPI #: _____ License #: _____

(Please Print)

Note: New York State prescribers must submit a state-approved prescription with this complete form.

3. Patient Clinical Information

Patient Diagnosis/*ICD-10* Code:

B57. _____ Other: _____

B57. _____ Other: _____

4. Patient Information

Patient Name: _____ Patient Date of Birth: ____/____/_____

Shipping Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Best Time to Call: _____

Primary Language: _____

Email Address: _____

5. Physician Declaration

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Benznidazole Tablets based on my professional judgment of medical necessity.

I represent and warrant that I have my patient's HIPAA authorization on file to disclose his/her health information and to transfer such authorization to Foundation Care and Exeltis and their agents to use and disclose such information as necessary to forward this prescription to a dispensing pharmacy on behalf of my patient and to evaluate this patient for qualification for the Exeltis PAP.

Physician Signature: _____ Date: _____

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The physician must fill out Sections 1 through 4 below and sign where indicated.

1. Physician Information

Physician Name: _____ Site/Facility Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Office Contact: _____ Telephone: _____ Best Time to Call: _____
Office Contact Email: _____ Fax: _____ Preferred Contact: ❑ Email ❑ Phone
License #: _____ Tax ID #: _____ NPI #: _____

2. Prescription

Upon confirmation of insurance coverage (or the patient's approval for assistance through the Program), medication will be shipped via a specialty pharmacy.

Prescriber Name: _____
Product Name: _____
Strength: ❑ 100 mg ❑ 12.5 mg
Directions: _____
Refill(s): _____ Quantity: _____
Physician Signature: _____ / _____ Date: _____
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Patient Diagnosis/*ICD-10* Code:
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Physician Signature: _____ Date: _____

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