VELCADE REIMBURSEMENT ASSISTANCE PROGRAM

ENROLLMENT FORM

Millennium Pharmaceuticals, Inc. (the "Company") is able to assist healthcare providers, patients and caregivers with the process of insurance verification and if requested, to determine eligibility through the VELCADE Reimbursement Assistance Program (the "Program"). To assist in this process the following information is required to enable the Reimbursement Specialist to verify health insurance coverage and eligibility; obtain preauthorization; assess each patient's drug coverage; and clarify any co-payment obligations patients may have with regards to VELCADE™ (bortezomib) for Injection.

Please complete the information below for each patient and **fax** to the **VELCADE Reimbursement Assistance Program** at **1-800-891-9843.** Please call **1-866-VELCADE (1-866-835-2233)** if you need to speak with a Reimbursement Specialist.

Service(s) Requested: ❒ **Insurance Verification** ❒ **Patient Assistance Eligibility** ❒ **Both**

Submission Date : _____ **New Application**_____ **Re-application** _____

Section 1--To be completed by patient or patient's representative and submitted to physician. (Please Print Clearly)

Name of Patient _____

Patient Representative (if applicable) _____

Patient's Street Address _____

City _____ State _____ Zip _____

Phone Number – Home (_____) _____ Work (_____) _____

Date of Birth _____/_____/_____ Social Security # _____ M _____ F_____ Marital Status_____

Insurance Information

Name of Insurance Company_____

Policy Number _____ Group Number _____

Subscriber's Name_____ Date of Birth_____ Relationship to Patient_____

Phone Number (_____) _____ Contact Person _____

Name of Secondary Insurance Company_____

Policy Number _____ Group Number _____

Subscriber's Name_____ Date of Birth_____ Relationship to Patient_____

Phone Number (_____) _____ Contact Person _____

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

If yes, program(s) applied to_____

Section 2 -- To be completed by prescribing physician. (Please attach copy of current State License)

Setting of Service: ❒ Private Practice ❒ Hospital Outpatient

Name of Physician _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____)_____Fax Number (_____)_____

Physician's Tax ID #_____ State License # _____ Expiration Date _____

Provider number (for Patient's insurance) _____

Office Contact Name and Professional Title _____ Phone Number (_____) _____

Patient Diagnosis _____ ICD-9: _____

List failed therapies _____

VELCADE Reimbursement Assistance Program **1-866-VELCADE**
PO Box 986, San Bruno, CA 94066 **Fax: 1-800-891-9843**

If eligibility for patient assistance is established, the completed **original form** with signature must be faxed or mailed to the address below.

VELCADE Reimbursement Assistance Program
MILLENNIUM Pharmaceuticals, Inc.
P.O. Box 986, San Bruno, CA 94066
Fax 1-800-891-9843
Toll Free # 1-866-VELCADE
1-866-835-2233

Financial Information

Financial Information- Only if applying for Patient Assistance

Annual Household Income _____
(Include Salary/Wages, Pension, Social Security, SSI, SS Disability, Unemployment)

Number of People in Household _____

Proof of Income is required before any drug is distributed.
Please attach a copy of most recent federal tax return or W-2.

Applicant Declaration

Financial Statement:

I certify that the information provided in this form is correct and complete. If needed, Millennium Pharmaceuticals, Inc. ("the Company") and the 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 my information will be verified every 6 months and that I will need to reapply to this Program every twelve months.

Permission for Sharing Personal Health Information:

To confirm that I qualify for the Program, my doctor may give a representative of the Program information about my health. My insurer and employer may give the Program information about my insurance. People who work for and with the Company to run the Program may see my health and insurance information and the information on this form, but they may use it only for this Program. The Program will make every effort to keep my information confidential, but if it is accidentally disclosed, federal privacy laws will not protect it.

This permission will last for one year from the time I apply to the Program. If I change my mind before one year has passed, I can call the Program's toll-free phone number and tell them that I have decided to leave the Program. I can also inform my doctor, insurer, or employer in writing that I do not want them to give the Program any more information. I know that this means I may no longer be able to receive assistance from the Program. I also understand that the Company has the right to change or end the Program 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.

X _____
Signature of Patient or Patient Representative (if signed by Representative, explain authority to act for the Patient)

_____
Name Date

Physician Declaration

To the best of my knowledge, this patient does not have any prescription drug coverage (including private insurance, Medicare, Medicaid, county funded assistance, or other public programs) for VELCADE™ (bortezomib) for Injection.

No claim may be made to any third party payer for payment of product provided under the Program. Product provided under the Program must only be used for the approved patient and may not be sold, traded or returned for credit. The VELCADE Reimbursement Assistance Program requests that physicians do not charge the patient for those professional services associated with this regimen that are not covered by the patient's health insurer.

Please indicate that you agree to these terms by signing below. Failure to comply with these terms may mean you (and any patients you treat) will no longer be eligible to participate in the VELCADE Reimbursement Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature : _____

Physician Name (Print): _____ Date: _____