



TORISEL™ Reimbursement Support and Patient Assistance Programs
 PO Box 220907, Charlotte NC 28222-0907
 Fax: 866-993-8411, Phone: 866-993-8466
 Patient Enrollment and Application Form

All items must be completed. This form may be used to inquire regarding Patient's coverage for TORISEL, or to apply for the Patient Assistance Program. Please be sure to include both patient and physician signatures below.

Requested services: Insurance Verification* Patient Assistance Program

Physician Information

Physician Name: _____ Site Name: _____

Select One: Physician Office Hospital Outpatient Hospital Inpatient Other

Practice Address: _____ City, State, ZIP: _____

Contact Name: _____ Phone #: _____ Fax #: _____

Treatment Information TORISEL™ (temsirolimus)

Dosage: _____ Treatment Start Date: _____

Product Shipping Address/Infusion Site (If different from above): _____

Patient Information

Patient Name: _____ Social Security #: _____ Male Female

Address: _____ City, State, ZIP: _____

Daytime Phone #: _____ Date of Birth: _____

Patient Insurance Information

I have no insurance coverage, including Medicaid or Medicare (Skip to Public Programs Section).

Primary Insurance Information (including Medicaid or Medicare)

Payer Name: _____

Policy #: _____ Group #: _____

Payer Phone #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Secondary Insurance Information

Payer Name: _____

Policy #: _____ Group #: _____

Payer Phone #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Public Programs

Have you applied for Medicaid, Medicare or other public assistance programs?

Yes Program Name: _____ Date Applied: _____

Status of Application: Approved Pending Denied (If denied, please enclose copy of denial)

No Do you intend to apply? Yes No If not, why? _____

Financial Information

Annual Household Income (gross): _____ Number of household members dependent on income: _____

Patient and Physician Declaration

I certify the information provided is correct and complete. I agree to notify the Program immediately should any of the information change. If Patient is applying for Patient Assistance Program, I certify that Patient is a U.S. resident, and has no government or private insurance to pay for the medication requested, or that paying for the medication from Patient's own resources or assets would cause Patient severe financial hardship. I agree that if this application is approved, the medication will be provided to Patient free of charge, and neither Patient nor any third party will be billed for the medication. I understand that, at any time, Wyeth may modify or discontinue any or all of the Program and related eligibility criteria, or terminate assistance provided by the Program. I have read and understand the Program guidelines and agree to comply with Program requirements.

Patient Signature

Date

Physician Signature

Date

*Insurance Verification is not a guarantee of payment.