MACUGEN® (pegaptanib sodium injection) Access Program™ (MAP) Enrollment Form

MAP helps patients and healthcare providers secure access to and coverage for Macugen®. MAP offers the following services to patients and physicians:

Reimbursement Counseling: MAP counselors will see if Macugen® is covered by a patient's insurance provider. MAP counselors can also assist with the prior-authorization process, coding questions, claim denials, and the appeals process.

Patient Assistance: Patients may be considered for the patient assistance program if they don't have insurance coverage or Macugen® is not covered by their insurance plan.

Patients without insurance coverage may be provided Macugen® at no cost if they meet pre-established eligibility criteria. These include the following:

1. Completed MAP enrollment form (with patient and physician signatures)

2. Documentation of household income
   - Acceptable forms of income documentation include the patient's IRS 1040 form from the most recent tax year, W-2, or Social Security Benefit statement.
   - Once the MAP enrollment form is completed, signed, and returned to MAP, the program can begin to provide services if the patient qualifies.
   - The patient's income documentation must be provided to MAP within 45 days after the enrollment form is submitted to be considered for on-going participation.

3. Acknowledgement of US residency

Patients who have insurance but whose plans do not cover Macugen®, through lack of prescription drug coverage or other reasons, may also be considered for the patient assistance program. To be eligible for assistance through MAP, the patient must meet pre-established eligibility criteria, provide items 1 through 3 above, and follow the steps set forth in items A through D below:

A. Insurance coverage for Macugen® should be verified by MAP prior to starting treatment with Macugen® (recommended). MAP must be notified by the physician within 60 days after the first claim denial. Enrollment in the program can occur after the initiation of treatment, within 60 days after the first claim denial, however, patients must meet the pre-establishd criteria to qualify for the program.

B. Prior authorization for Macugen® must have been obtained if required

C. The patient's physician must ensure appropriate and timely action with the patient's insurance company, including:

   - Filing a claim form with all the necessary information with the applicable insurer

D. Physician must appeal denied claims and must do so in accordance with insurer's and MAP's Guidelines

MAP
PO Box 220662
Charlotte, NC 28222-0662
Phone: (866) 272-8838
Fax: (866) 272-8839

MACUGEN® (pegaptanib sodium injection) Access Program™ (MAP) Enrollment Form

Please complete each section. Return this completed application to:

MAP
PO Box 220662, Charlotte, NC 28222-0662
Telephone: 866-272-8838 Fax: (866) 272-8839

PATIENT INFORMATION (complete or include demographic sheet)

Patient Name: _____
SS#: _____ DOB_____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: _____Evening Phone: _____

INSURANCE INFORMATION (complete or include demographic sheet)

Primary Insurance
Health Insurance Company: _____
Telephone: _____
Policy ID #:_____ Group #:_____
Subscriber Name: _____ Date of Birth: _____
Prescription Card #: _____ Carrier: _____
Do you have any **secondary insurance**, including **Medicare**?
☐ NO ☐ YES
Secondary Insurance Company:_____
Telephone: _____
Policy ID#:_____Group#:_____
Subscriber Name:_____

FINANCIAL INFORMATION (Patient Assistance Only)

Current gross annual household income: $_____
Number of members in household: _____
Income Source: ☐ 1040 ☐ W-2 ☐ Social Security Benefit Statement

I, _____ (patient's name) verify that the information provided in this application is complete and accurate. I understand that I must provide proof of income to MAP within 45 days of enrollment in the Patient Assistance Program. I do not have the financial resources to pay for Macugen®. I agree that if I am eligible and receive any free product that I will not submit a claim to seek reimbursement from my health care insurer for such free product. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that Eyetech reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

PATIENT AUTHORIZATION (Required)

I authorize my healthcare providers and health plans to disclose my protected health information ("PHI") to Eyetech Inc. and its agents and contractors ("Eyetech Inc.") to: (1) establish my eligibility for benefits through the Macugen® Access Program™; (2) communicate with my health care providers and me about my medical care; and (3) provide Macugen® (pegaptanib sodium injection) support services including facilitating the provision of Macugen® to me. I understand that once my PHI has been disclosed to Eyetech Inc., federal privacy laws may no longer restrict its further disclosure. Eyetech Inc. agrees to use and disclose this information only for the above purposes and as permitted by law.

I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Eyetech Inc. in writing and submitting the cancellation by fax to: 1-866-272-8839. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient Signature: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN INFORMATION

Physician Name: _____
NPI#: _____ DEA #: _____
Tax ID #/Provider ID#: _____
State License #: _____
Site/Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Contact Name: _____

DELIVERY INFORMATION
(Please indicate shipping address if different from above)

Site/Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Delivery Contact Name: _____
Tel: _____ Fax: _____

CLINICAL INFORMATION

For which eye(s) does the patient require Macugen®?

☐ Left Eye ☐ Right Eye ☐Bilateral

Diagnosis (s) _____

PHYSICIAN CERTIFICATION

I attest that the information provided is current, and accurate to the best of my knowledge. I certify that Macugen® is medically necessary for this patient and I will be supervising the patient's treatments. I have obtained from my patient all required authorizations for the release to Eyetech Inc. and its agents and representatives of my patient's identification and insurance information. I understand that any information provided is for the sole use of Eyetech Inc. and its agents and representatives to verify my patient's insurance coverage and to assess, if applicable, patient's eligibility for participation in the patient assistance program ("PAP") and to otherwise administer MAP. I understand that application to the PAP does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the PAP, and I agree to immediately notify MAP if I become aware of such a change in status. I certify that I will not bill for or accept payment from patients (or any third party), in whole or in part, for Macugen® obtained through the PAP. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for Macugen® supplied through the PAP, I will immediately notify a MAP representative, and I understand that in such event Eyetech Inc. will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe Macugen® and that I have not received nor will I receive any benefit from Eyetech Inc. or its agents or representatives for prescribing Macugen®.

Physician Signature: _____ Date: _____

MACUGEN® Access Program (MAP)™ PO BOX 220662 Charlotte, NC 28222-0662 Phone (866) 272-8838 Fax (866) 272-8839	**FAX COVER PAGE**
To:	Fax Number:
From: Extension:	Date/Time:
Subject:	Pages:

Please note that third-party reimbursement is affected by many factors, and Eyetech Inc. makes no representations or guarantees that you will be successful in obtaining insurance reimbursement or any other payment. This is not intended as a prohibited referral under applicable laws and regulations.

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