CUBICIN® (daptomycin for injection)
INSURANCE VERIFICATION/PATIENT ASSISTANCE PROGRAM FORM

Phone: 1-877-282-4786
Fax: 1-866-428-2478

REQUEST TYPE

☐ Insurance Verification/Precertification
☐ Patient Assistance Program—**PLEASE NOTE:** This program only offers product replacement for product provided to patients who are completely uninsured if they meet other eligibility criteria. **This program does not offer financial assistance.**

REQUEST SUBMITTED BY ☐ Physician ☐ Treating Facility

Contact Name:	
Phone #:	Fax #:

PHYSICIAN INFORMATION

Physician Name:		Specialty:	
Facility Name:			
Address:	City:	State:	ZIP Code:
NPI #:	Tax ID #:	DEA #:	

TREATMENT INFORMATION

Site of Service: ☐ Physician Office ☐ Hospital Outpatient (HOPD) ☐ Home Health
☐ Other (please specify): _____

Dates of Service at the Site of Service Selected Above	Start Date:	End Date:
Number of Vials Requested:	Dosing (mg/kg):	ICD-9-CM Code:
Dispensing Facility Name:		
Address:	City:	State: ZIP Code:

PATIENT INFORMATION

Patient Name:			Phone #:	
Gender: ☐ M ☐ F	Date of Birth:		Weight (kg):	US Resident: ☐ Yes ☐ No
Address:	City:	State:	ZIP Code:	

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

Primary Insurance:	Secondary Insurance:
Insurance Phone #:	Insurance Phone #:
Policy #:	Policy #:

FINANCIAL INFORMATION (only complete if applying for Patient Assistance Program)

Total Annual Household Income*: $	Household Size (including patient):

*Include proof of household income (1040, 1040EZ, SSI/SSDI Letter, Notarized Letter, etc.).

SIGNATURES

For Insurance Verification/Precertification: Patient ***or*** physician signature is required.
For Patient Assistance Program: Patient ***and*** physician signatures are required

Patient: I have read and agree to the Applicant Declaration on the back of this form.

X _____ Date: _____

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

Patient or Patient Representative Name (print): _____

Authority: ☐ Power of Attorney ☐ Limited Power of Attorney ☐ Other (please specify) _____

Physician: I have read and agree to the terms detailed on the back of this form.

X _____ Date: _____

Physician's original signature (no stamped signatures)

APPLICATION DECLARATION

I verify that the information provided in this application is complete and accurate to the best of my knowledge. I authorize the disclosure to Covance (or other Cubist vendor responsible for operating the CUBICIN Patient Assistance Program) of the information requested on the Insurance Verification/Patient Assistance Program Form, including demographic information about me (for example, name and date of birth), as well as information concerning my health insurance, medical history and current condition, information about my financial status, and other information that may be reasonably required by Covance that is related to this information (all of this information is referred to as "Personal Information" in this form) for the purposes of determining my eligibility for participation in the CUBICIN Patient Assistance Program or obtaining information on insurance coverage and payment from Cubist. Once my Personal Information has been disclosed by me or my treating physician or provider and my health insurer (if any) to Covance, federal privacy laws may no longer protect the information from further disclosure. I understand that my treating physician or provider, my insurance company (if any), and Covance will likely need to communicate regarding any or all of this Personal Information as well, and I hereby authorize such electronic, oral, or written interaction regarding this Personal Information. I also understand that Covance will not disclose to Cubist any information that identifies me and will only use my Personal Information for the purposes set forth above.

I understand that I do not have to sign this authorization, but if I do not, Covance will not be able to verify my insurance coverage for CUBICIN or determine if I am eligible to participate in the Patient Assistance Program. My treating physician or provider and my health insurer (if any) will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this authorization. Regardless, I may have to pay for CUBICIN myself. I understand that I may revoke this authorization at any time by mailing or faxing a written request to the treating physician or provider to revoke the authorization, except to the extent that the treating physician or provider has taken action in reliance on my authorization. I also understand that I may inspect or copy the information disclosed pursuant to this authorization.

I am entitled to a copy of this authorization; this authorization expires 1 year from the date of my signature.

By submitting this application, the treating physician or provider agrees to the following:

- Cubist Pharmaceuticals' product CUBICIN will be provided to patients in a medically appropriate manner based on current standards of medical care.
- Cubist Pharmaceuticals' Patient Assistance Program provides free product for uninsured patients needing CUBICIN who have been determined by Cubist to meet its eligibility criteria, including financial criteria. Cubist Pharmaceuticals reserves the right to change or terminate this program at any time or to refuse to distribute the product under this program to any patient or provider.
- CUBICIN has been prescribed for the patient listed on this Insurance Verification/Patient Assistance Program Form. The patient has consented to and authorized the provision of this information.
- No third party, including Medicaid or other public programs, or patient has been or will be charged for the product for which replacement is sought from Cubist Pharmaceuticals under the CUBICIN Patient Assistance Program. All product received in connection with the CUBICIN Patient Assistance Program will replace product used for the treatment of uninsured patients who have been determined by Cubist to meet the CUBICIN Patient Assistance Program eligibility criteria. No part of such replaced product can be claimed as bad debt. No free product will be sold or distributed for sale.
- The information contained in this form is complete and accurate to the best of my knowledge. If the patient submits written information to the facility/practice that would affect CUBICIN Patient Assistance Program eligibility, including, but not limited to, revoking the consent that allows the facility/practice to provide patient information on the Insurance Verification/Patient Assistance Program Form, the CUBICIN Patient Assistance Program will be notified immediately by telephone at 1-877-CUBIST-6 (1-877-282-4786), or fax at 1-866-4CUBIST (1-866-428-2478).