Eliquis 360 Support

# Benefit Review Form for ELIQUIS® (apixaban) 2.5 mg and 5 mg Tablets

Ph: 855-ELIQUIS  Fax: 855-674-8134

**1. Please indicate the type of service needed** ☐ Benefit Review ☐ Prior Authorization ☐ Appeals

**2. Is patient currently in the hospital?** ☐ Yes ☐ No

If yes, please provide primary point of contact within the hospital: _____ (Name) _____ (Phone)

## 3. Patient Information

Patient Name _____ (First name) _____ (Last name) ☐ Male ☐ Female Birth Date ___/___/___

Address _____ City _____ State _____ Zip _____

Home/Cell Phone _____ Work Phone _____

Best Time to Contact _____ E-Mail _____

## 4. Patient Insurance Information

**Primary Insurance** _____ Insurance Co. Phone _____

Cardholder _____ Relationship to Cardholder _____

Employer _____ Policy # _____ Group # _____

**Prescription Drug Insurance** _____ Card/BIN # _____ Phone _____

Cardholder _____ Relationship to Cardholder _____

## 5. Provider Information

Prescriber Name _____ (First name) _____ (Last name) Specialty _____ Practice Name _____

Address _____ City _____ State _____ Zip _____

Office Contact _____ (First name) _____ (Last name) Phone _____ Fax _____

E-Mail _____ Tax ID # _____ UPI #/NPI # _____

Primary Physician or Cardiologist _____ (If different from prescriber above) Phone _____ Fax _____

## 6. Clinical Information

Patient Diagnosis – ICD Code _____ ELIQUIS® (apixaban) Prescribed Dosage (mg) ☐ **2.5 mg Tablet** ☐ **5 mg Tablet**

☐ **12-Day Supply** ☐ **30-Day Supply** ☐ **35-Day Supply**

☐ **60-Day Supply** ☐ **90-Day Supply**

## 7. Comprehensive Coverage Research (Complete this section if you would like this service)

Comprehensive Coverage Research provides assistance to my patient in researching alternative methods of coverage (such as Medicare Part D "Extra Help" also known as Low Income Subsidy "LIS") of ELIQUIS.

Household Size _____ Total Yearly Combined Household Income (Before Taxes) _____

## 8. Provider Certification

I certify that, to the best of my knowledge, the information in the form is complete and accurate. I certify that I have the authority to disclose this patient's information and have obtained, if required by HIPAA or other applicable privacy laws, this patient's authorization for the disclosure.

I certify that I have prescribed the product based on my professional judgment of medical necessity and for an FDA-approved use.

SIGN HERE

_____ (Physician Signature) ___/___/___ (Date)

Please see below for Patient Authorization. Once both **Physician and Patient sign**, fax completed forms to: 855-674-8134.
Incomplete or incorrect information may delay the process. Please ensure all information is provided correctly and signatures are obtained.

Please see U.S. Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, or visit ELIQUIS.com.



FOR HEALTHCARE PROFESSIONAL USE ONLY

# Patient Authorization and Agreement Form

The patient support program for ELIQUIS® (apixaban) (the "Program") is designed to provide you with reimbursement support services. To participate in the Program we will need to receive, use, and disclose your personal information. Please read this form carefully and contact Bristol-Myers Squibb and Pfizer at 1-855-ELIQUIS if you have any questions. Fax the signed copy to 1-855-674-8134.

**What information will be used and disclosed?**
My personal information will be used and disclosed, including the information on this form, my contact information, date of birth, health information and health records, financial and income information, and insurance information.

**Who will disclose, receive, and use the information?**
This authorization permits my healthcare providers, pharmacists, health plans, and health insurers who provide services to me ("my service providers") to disclose my personal information to Bristol-Myers Squibb, Pfizer, and their authorized agents and assignees. Bristol-Myers Squibb, Pfizer and their authorized agents and assignees may also share it with other healthcare providers, pharmacists, health insurers, and charitable organizations to determine if I am eligible for, or enrolled in, another plan or program.

**What is the purpose for the use and disclosure?**
My personal information will be used by and shared with the persons and organizations described above in order to process my application and provide the Program's services to me, including to verify my insurance benefits, research insurance coverage options, determine my eligibility for the ELIQUIS co-pay assistance program, refer me to other plans or assistance programs that may be able to help me and improve or develop the Program's services. The Program may also contact my service providers and me about the Program and the services that are available as well as contact other healthcare providers and charitable organizations to determine if I'm eligible for, or enrolled in, another plan or program.

**When will this authorization expire?**
This authorization will be effective for 2 years unless it expires earlier by law or I cancel it in writing.

I understand that once my health information has been disclosed to the Program, privacy laws may no longer restrict its use or disclosure. The Program agrees to protect my information by using and disclosing it only for the purposes described in this authorization or as allowed or required by law. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the Program services. I may also cancel this authorization, in whole or in part, in the future by writing to:

ELIQUIS® (apixaban) Reimbursement
P.O. Box 220688
Charlotte, NC 28222-0688

If I cancel this authorization, the Program will stop using or disclosing my information for the purposes listed here, except as allowed or required by law or as necessary to end my participation in the Program. I also have a right to receive a copy of this form after I have signed it.

I certify that the personal information that I provide to the Program is true and complete. I agree that, at any time during my participation in the Program, Bristol-Myers Squibb, Pfizer and their agents may request additional documentation to verify my personal information. I understand that the Program may be discontinued or the rules for participation may change at any time without notice.

I would like to enroll in the Program and have read this form and agree to its terms:

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

SIGN HERE

Signature of Patient or Personal Representative

Date

**The patient or his/her personal representative must be provided with a copy of this Patient Authorization and Agreement Form after it has been signed.**