

**Insurance Benefit Verification Form: DOXIL® (doxorubicin HCl liposome injection)****DOXILine®: 1-800-609-1083**

Please complete and fax this form to 1-(800) 987-5572 or mail to DOXILine®, P.O. Box 220247, Charlotte, NC 28222-0247.

**Patient Information**

PATIENT NAME \_\_\_\_\_ DOB (MM/DD/YYYY) \_\_\_\_\_ [ ] MALE [ ] FEMALE  
 NAME OF GUARDIAN (IF APPLICABLE) \_\_\_\_\_  
 PATIENT ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 PRIMARY PHONE \_\_\_\_\_ SECONDARY PHONE \_\_\_\_\_  
 SOCIAL SECURITY NUMBER \_\_\_\_\_ CAN WE CONTACT THE PATIENT DIRECTLY? [ ] YES [ ] NO

**Insurance Information**

PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
PRIMARY INSURANCE PHONE _____	SECONDARY INSURANCE PHONE _____
CARDHOLDER _____	CARDHOLDER _____
CARDHOLDER DOB (MM/DD/YYYY) _____	CARDHOLDER DOB (MM/DD/YYYY) _____
RELATIONSHIP TO CARDHOLDER _____	RELATIONSHIP TO CARDHOLDER _____
POLICY # _____	POLICY # _____
GROUP # _____	GROUP # _____
PROVIDER ID # FOR INSURANCE _____	PROVIDER ID # FOR INSURANCE _____
RX CARD PATIENT ID _____	

**Patient Authorization for DOXILine® Services**

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Janssen Products, LP, and companies working on their behalf, including vendors, other affiliates, specialty pharmacies, and other service providers supporting DOXILine® as defined on the Patient Copy (collectively, "Janssen").

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PATIENT NAME \_\_\_\_\_

If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME \_\_\_\_\_ BY \_\_\_\_\_  
 Signature of person legally authorized to sign for patient

NAME OF PERSON LEGALLY AUTHORIZED TO SIGN RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

**Physician Information**

NAME OF FACILITY \_\_\_\_\_ FACILITY TAX ID # \_\_\_\_\_  
 FACILITY MEDICARE PROVIDER ID # \_\_\_\_\_ FACILITY MEDICAID PROVIDER ID # \_\_\_\_\_  
 NAME OF PHYSICIAN \_\_\_\_\_ SPECIALTY \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 PHONE \_\_\_\_\_ FAX \_\_\_\_\_  
 OFFICE CONTACT \_\_\_\_\_ OFFICE CONTACT PHONE \_\_\_\_\_  
 TAX ID # \_\_\_\_\_ NPI # \_\_\_\_\_

**Drug Therapy**

PATIENT DIAGNOSIS \_\_\_\_\_ ICD-9 CODES \_\_\_\_\_  
 HAS PATIENT STARTED DOXIL® THERAPY? [ ] YES [ ] NO - IF YES, START DATE \_\_\_\_\_  
 ADDITIONAL INFORMATION REGARDING TREATMENT (IF APPLICABLE TO BENEFITS VERIFICATION) \_\_\_\_\_

**Prior Authorization: If you would like DOXILine® to provide support for prior authorization process, please check the appropriate box(es)****[ ] PRIOR AUTHORIZATION FORM PREPARATION**

By checking this box, I request that DOXILine® assist my office in addressing the requirements of this patient's health plan related to prior authorization for treatment with DOXIL®. I understand that assistance includes obtaining the health plan-specific prior authorization form, and completing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by DOXILine® for possible submission to the health plan.

**[ ] PRIOR AUTHORIZATION STATUS MONITORING**

By checking this box, I request that DOXILine® actively monitor the status of the prior authorization submission. I request that DOXILine® provide status updates to my office with respect to this patient's prior authorization for treatment with DOXIL®.

BEFORE PRESCRIBING DOXIL® (DOXORUBICIN HCL LIPOSOME INJECTION), PLEASE SEE FULL PRESCRIBING INFORMATION, INCLUDING *BOXED WARNING*, *CONTRAINDICATIONS*, *WARNINGS*, *PRECAUTIONS*, AND *ADVERSE REACTIONS*, AVAILABLE AT WWW.DOXIL.COM.

Patient insurance benefit investigation is provided as a service by the support services administrator under contract for Janssen Products, LP. In this regard, the support services administrator assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the providers' exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, the support services administrator, and Janssen Products, LP, make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While the support services administrator tries to provide correct information, it and Janssen Products, LP, make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator, or Janssen Products, LP, or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Janssen Products, LP, assumes no responsibility for, and does not guarantee, the quality, scope, or availability of the services including but not limited to reimbursement support services, patient education, and other support services. Each provider, not Janssen Products, LP, is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

**Before prescribing DOXIL® (doxorubicin HCl liposome injection), please see full Prescribing Information, including *boxed warning, contraindications, warnings, precautions, and adverse reactions*, available at [www.doxil.com](http://www.doxil.com).**



## PATIENT COPY

### **Provider Instructions**

- 1. Have the patient read this form and sign the acknowledgement on the front of the Insurance Benefit Verification Form relating to the Patient Authorization.**
- 2. Provide the patient with this sheet and a copy of the front of the Insurance Benefit Verification Form which they have signed.**

### **PATIENT AUTHORIZATION (PA)**

My signature on the front of the Insurance Benefit Verification Form confirms that I authorize each of my physicians, and other healthcare providers (together “Healthcare Providers”) and each of my health insurers (together, “Insurers”) to disclose my protected health information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, “Protected Health Information”) to Janssen Products, LP, its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients (DOXILine®) (together “Janssen”) for the purposes described below.

Specifically, I authorize Janssen to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me and/or the person legally authorized to sign on my behalf, about DOXILine® programs; (ii) provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to DOXIL®; (iii) verify, investigate, assist with, and coordinate my coverage for DOXIL® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of DOXIL®. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws. I understand that I am not required to sign the front of the Insurance Benefit Verification Form. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the front of the Insurance Benefit Verification Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from DOXILine®.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to DOXILine®, P.O. Box 220247, Charlotte, NC 28222-0247. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen, but this will not affect Janssen’s ability to use and disclose Protected Health Information that it has received prior to its receipt of notification that I wish to discontinue my participation in the program. My authorization will also end if DOXILine® is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen.

Please read the Medication Guide for DOXIL®, available at [www.doxil.com](http://www.doxil.com), and discuss any questions you have with your doctor.

