

**INSURANCE BENEFIT VERIFICATION FORM**  
**DOXIL<sup>®</sup>** (doxorubicin HCl liposome injection)

DOXILine<sup>®</sup> 1-800-609-1083  
Monday-Friday 9 AM-8 PM ET

Mail to: DOXILine P.O. Box 220247 Charlotte, NC 28222-0247 Fax: 1-800-987-5572

Please print and mail or fax along with patient authorization.

**PATIENT INFORMATION**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Name of Guardian (if appropriate)

\_\_\_\_\_  
Patient Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Number--Home Work

\_\_\_\_\_  
Social Security Number Date of Birth

M \_\_\_\_ F \_\_\_\_

Can we contact the patient directly? Yes \_\_\_\_ No \_\_\_\_

**INSURANCE INFORMATION**

\_\_\_\_\_  
Name of Insurance Co. Policy Number Group Number

(\_\_\_\_\_) \_\_\_\_\_  
Phone Number Provider ID # For Insurance

\_\_\_\_\_  
Subscriber's Name Date of Birth

\_\_\_\_\_  
Subscriber's Relationship to Patient

\_\_\_\_\_  
Secondary Insurance Co. Policy Number Group Number

(\_\_\_\_\_) \_\_\_\_\_  
Phone Number Provider ID # For Insurance

\_\_\_\_\_  
Subscriber's Name Date of Birth

\_\_\_\_\_  
Subscriber's Relationship to Patient

**PHYSICIAN INFORMATION**

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Name of Physician Specialty

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Number Fax Number

\_\_\_\_\_  
Office Contact Phone Number

\_\_\_\_\_  
National Provider Identification (NPI) Number

\_\_\_\_\_  
Provider Tax ID Number

**DRUG THERAPY**

Patient Diagnosis: \_\_\_\_\_

ICD-9 Code/s: \_\_\_\_\_

Has patient started DOXIL therapy? Yes \_\_\_\_ No \_\_\_\_

If Yes, start date: \_\_\_\_\_

For cancer patients, is the patient on chemotherapy? Yes \_\_\_\_ No \_\_\_\_

Additional Information regarding treatment: (if applicable to benefits verification):  
\_\_\_\_\_  
\_\_\_\_\_

**Authorization to Share Health Information for Reimbursement Services**

**Provider Instructions: Patients must complete this form before they can participate in the Program.**

I, \_\_\_\_\_, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for Doxil<sup>®</sup> (doxorubicin HCl liposome injection) to The Lash Group, Inc., Ortho Biotech, Centocor, Inc., and Centocor Ortho Biotech Services, LLC (the “Companies”). The Lash Group, Inc. runs the DOXILine Program (the “Program”) for Ortho Biotech Products, L.P., the distributors of Doxil.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

The Companies may use and give out my information solely in connection with the Program, to see if I qualify for the program, run the Program, or as otherwise as required or allowed under law. People who work for and with the Companies may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

I understand that the Companies may contact me by telephone, postal mail or email (if I provided an email address) in connection with my enrollment in the Program and this authorization. This Authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with the Companies, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to the Companies.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: \_\_\_\_\_

By: \_\_\_\_\_  
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:

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A copy of this form must be provided to the patient.