



# Factor Solutions



## Gap Coverage Card Application

*Your Privacy is Our Priority*

Program managed by third-party agency - PAREXEL

P.O. Box 230133 • Centreville, VA • 20120 • Phone: 800-288-8374 • Fax: 800-390-1826

To avoid any delay in processing your request, application must be completed and signed. Your personalized Gap Coverage Card will be mailed to your home address upon meeting eligibility criteria. **Incomplete applications will be returned.**

Please print or type.

Federal healthcare program beneficiaries are not eligible.

Therapy **MUST** be for hemophilia A. Patient **MUST** be a legal resident of the United States.

### Patient Information

M / F

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

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

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP Code \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Is the patient a legal U.S. Resident? Yes  No

### Insurance Information

Reason for Insurance Lapse (during redemption) - \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Policy ID Number \_\_\_\_\_

**Patient Certification:** I certify that the information provided in this application is complete and accurate to the best of my knowledge. I hereby permit Bayer or its agent, PAREXEL, or authorized designee to contact my physician to request information concerning my medical condition and I hereby direct my physician to provide information relative to my medical condition, treatment or drug therapy as requested. I agree that Bayer or its agent PAREXEL or authorized designee may contact my insurer to obtain information about my drug therapy, and I hereby direct my insurer to provide information relative to my drug therapy coverage as requested. I understand that any and all information that I provide may be shared with my treating physician. I agree that at such time as I obtain insurance coverage for Kogenate® FS [Antihemophilic Factor (Recombinant), Formulated with Sucrose], I will notify PAREXEL. I understand that Bayer or its agent PAREXEL and authorized designees agree not to disclose any information obtained from my physician, my insurer, and me to any third party except as required by applicable law. I understand that Bayer reserves the right at any time to modify the application form or terminate assistance provided by the program.

Original signature of Patient / Guardian: (I understand that this program is subject to eligibility requirements)

Date: \_\_\_\_\_

### Healthcare Provider Information

HCP Name/Professional Designation \_\_\_\_\_

State License# \_\_\_\_\_ DEA # \_\_\_\_\_

Tax ID # \_\_\_\_\_

Contact Name \_\_\_\_\_

Facility/Practice Name \_\_\_\_\_

Street Address \_\_\_\_\_

Department/ Room# \_\_\_\_\_

City, State, ZIP Code \_\_\_\_\_

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

### Product Utilization Information

Average Monthly Use (in IU) \_\_\_\_\_

Previous Year Utilization (in IU) \_\_\_\_\_

This form and prescription may be faxed to: 800-390-1826

**Healthcare Provider Certification:** I certify that the information submitted on this form is true to the best of my knowledge and that in the event that medication is received in response to this submission it will be used to treat **ONLY** the patient described. I further certify that the use of the indicated pharmaceutical(s) is medically necessary and I will be supervising the patient's treatment. I understand that Bayer reserves the right at any time to modify the application form or terminate assistance provided by the program.

Original signature of licensed provider: (I understand that this program is subject to eligibility requirements)

\_\_\_\_\_

Date: \_\_\_\_\_