Humate-P®
Antihemophilic Factor/von Willebrand Factor Complex (Human)

Helixate®FS
Antihemophilic Factor (Recombinant)

My Access® Cost Share Assistance Program Patient Enrollment Form

P.O. Box 4133 | Gaithersburg, MD 20878 - 4133

Toll-free number: 1-800-676-4266 • Toll-free fax: 1-844-727-2757

All information on this enrollment form is required to determine eligibility for this program

Your Information

Name ______________________ Date of Birth ____________ [ ] Male [ ] Female

Address ______________________

City, State, ZIP ______________________

Phone Number ______________________ Email Address ______________________

How did you hear about this program? [ ] Physician [ ] Website [ ] Sales Rep [ ] Peer Referral [ ] Advertisement

Therapy Status: [ ] New to Therapy [ ] Existing Therapy [ ] Switch from Product [ ] Other

Insurance Information

Primary Insurance Company ______________________ Phone Number ______________________

Policy Number ______________________ Group Number ______________________

Policy Holder Name ______________________ Policy Holder Date of Birth ______________________

Secondary Insurance Company ______________________ Phone Number ______________________

Policy Number ______________________ Group Number ______________________

Policy Holder Name ______________________ Policy Holder Date of Birth ______________________

Facility Information

Select Dispensing Entity: [ ] Special Pharmacy [ ] Hemophilia Treatment Center [ ] Hospital Outpatient Department

Facility Name ______________________ Facility Contact ______________________

Address ______________________ City, State, ZIP ______________________

Phone Number ______________________ Fax Number ______________________

Cost Share Assistance Information

Humate-P & Helixate FS Cost Share Benefit

This program covers up to $12,000 in eligible out-of-pocket expenses per year for Products only (medical services / supplies are not covered)*

* No age restrictions. Patients must be U.S. residents, and insured in the U.S. Patients covered by state- or federally funded programs, such as Medicare, Medicaid, PCIP, Champus, TriCare, or Veterans Health Insurance, are NOT eligible. You can only receive assistance for the cost of Humate-P & Helixate FS purchased from Specialty Pharmacies, Hemophilia Treatment Centers, and Out Patient Hospital Services, but not for the cost of related medical services for administration. CSL Behring reserves the right to terminate, discontinue, modify or limit all or any portion of the program at any time without notice and for any/no reason at its sole discretion.

CSL Behring My Source[SM] provides a variety of additional patient support services for patients. In order to tell you more about these offerings and potentially register you to take advantage of these additional services, we need to confirm that we have your consent on file.

By providing consent you are choosing to participate in patient support services provided by CSL Behring through My Source and/or receive new patient resources from CSL Behring, especially those that may make your infusion process easier.

[ ] No, I am not interested in this benefit

Authorization

The information on this form is accurate and complete. I hereby authorize my healthcare providers, health plans, and insurers to release medical and other pertinent information to My Source and/or its authorized designee for the sole purpose of determining medical insurance benefits.

Patient Signature______________________ Date_____/_____/_________

The confidentiality of patient information is of utmost importance. Therefore, CSL Behring and its agents comply with all federal, state, and local guidelines regarding patient confidentiality rights.

Please complete, print out, and sign this form and submit by fax to (1-844-727-2757) or mail to My Source, P.O. Box 4133, Gaithersburg, MD 20878-4133

My Access® is a registered trademark and My Source[SM] is a service mark of CSL Behring LLC.