

## PATIENT ASSISTANT PROGRAM (PAP) PATIENT ENROLLMENT FORM INSTRUCTIONS

Thank you for your interest in applying to the ENcourage Foundation<sup>®</sup>. The Foundation is a nonprofit organization that provides Enbrel<sup>®</sup> (etanercept) to qualifying patients at no cost.

## ELIGIBILITY GUIDELINES

- **Residence:** You must reside in the United States, Guam, Puerto Rico or the U.S. Virgin Islands
- **Income:** You and your household member's combined Annual Adjusted Gross Income do not exceed our program guidelines
- **Insurance:** You have no or limited coverage for ENBREL

## HOW TO APPLY

- **Patient:** Complete PATIENT INFORMATION (page 1 of application) and sign and date Patient Consent (page 2 of application)
- **Provider:** Complete PRODUCT PRESCRIPTION FORM (page 3 of application)
- **Provider:** FAX completed application to **(888) 508-8083**

## NEXT STEP

Once we receive your completed application, both you and your physician will be notified of your eligibility. For any questions, please call (800) 282-7752, Monday through Friday, 9am to 9pm Eastern Time.

## PATIENT INFORMATION

Patient Name:				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last	First	M.I.			
Date of Birth:    /    /	Social Security Number:    -    -	U.S. Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Patient Address:					
Street		City	State	Zip	
Telephone:					
(    )    -		(    )    -			
<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work			
Current Adjusted Gross Household Income: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly					\$    .
Total Number of People Within Household (including yourself):					
Are you enrolled in Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emergency Only					
Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Medicare ID #:					
Are you enrolled in Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending					
Do you have commercial insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please complete below as applicable:</i>					
PRIMARY Insurance	Insurer:		Phone #:    (    )    -		
	Subscriber Name:		Relationship to Patient:		
	Policy Number:		Group Number:		
SECONDARY Insurance	Insurer:		Phone #:    (    )    -		
	Subscriber Name:		Relationship to Patient:		
	Policy Number:		Group Number:		
PHARMACY Insurance	Insurer:		Phone #:    (    )    -		
	Subscriber Name:		Relationship to Patient:		
	Policy Number:		Group Number:		
Are you eligible for other federal, state, local government or charity care programs (VA/DOD)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please complete below as applicable:</i>					
OTHER	Program Name:		Policy Number:		
	Effective Date:    ____/____/____		Phone #:    (    )    -		

## PATIENT CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION

The ENCourage Foundation® (“the Foundation”) is a nonprofit patient assistance program supported by Amgen and Pfizer that provides qualifying patients with Enbrel® (etanercept) at no cost.

I authorize the Foundation, Amgen, Pfizer, their agents, and third-party contractors or their service providers authorized to administer the Foundation to:

- use the information that I provided on the Foundation application form to determine my eligibility for and assist with my continued participation in the Foundation.
- use my social security number to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process.
- contact me to seek feedback on the Foundation’s services.

For these purposes, I also authorize the sharing of information about my medical condition, treatment, and health insurance coverage between my physician, healthcare professionals, health plan(s), care givers, and family members and the Foundation, Amgen, Pfizer, their agents, and third-party contractors or their service providers authorized to administer the Foundation.

I certify that:

- the information I provided on the Foundation application form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for ENBREL that I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- I will not sell, trade, or distribute ENBREL given to me by the Foundation.

I understand that:

- completing the Foundation application form is not a guarantee of eligibility for the Foundation.
- the Foundation may change or discontinue the program at any time without notice.
- I may refuse to sign this form, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from the Foundation.
- my healthcare provider or insurers will not condition my medical treatment or insurance benefits on my agreement to sign this form.
- once I provide the information on the Foundation application form to the Foundation, Amgen, Pfizer, the agents, and third-party contractors or their service providers working on their behalf pursuant to this authorization, federal privacy laws may not prevent further disclosure of this information.
- I may receive a copy of this form or revoke it at any time by contacting the Foundation at 1-800-282-7752.
- this authorization will expire one (1) year after the date it is signed below or one (1) year after the last date I receive product from the Foundation, whichever is later.

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**Signature of patient  
or legal representative**

**Print Name of patient  
or legal representative**

**Date Signed**

*ENCourage Foundation® reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. ENCourage Foundation® also reserves the right to make an independent determination of financial need.*

## PRODUCT PRESCRIPTION FORM

<b>Patient</b>	Patient Name: _____		Gender:	Date of Birth:	
	LAST	FIRST	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	
<b>Physician</b>	First Name:	Last Name:	State License #:		
	Phone #: ( ) -	Fax #: ( ) -			
	Street Address: _____				
Street (PO BOX not accepted)		City	State	Zip	
<b>Facility/ Practice</b>	Facility/Practice Name:		Facility/Practice Contact Name: (other than physician)		
<b>PRESCRIPTION</b>	MEDICATION / DOSE		FREQUENCY	QUANTITY	REFILLS
	<b>Enbrel® (etanercept):</b>				
	<input type="checkbox"/> 50mg SureClick®		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly for 3 months; then once weekly <b>(Step-down Dosing)</b>	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> 50mg Prefilled Syringe		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly for 3 months; then once weekly <b>(Step-down Dosing)</b>	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> 25mg Vial		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> 25mg Prefilled Syringe		<input type="checkbox"/> Once weekly <input type="checkbox"/> Twice weekly	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	<input type="checkbox"/> _____		<input type="checkbox"/> _____	_____	<input type="checkbox"/> 1 year or <input type="checkbox"/> x _____
	Prescription length is 12 months unless otherwise noted here:				
<b>New Enrollees/Step-down Dosing:</b> Shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.			<b>Re-enrollees:</b> 4 shipments of 3 months' supply each on a 1 year refill prescription.		
<b>SHIPMENT INSTRUCTIONS:</b> ENBREL is shipped to the patient directly. If you prefer to have the product shipped to the Physician's office instead, please check here: <input type="checkbox"/> Ship to Physician's Office					

I have prescribed ENBREL for the above patient. My patient gave consent for me to provide this information. I understand that no third party or patient should be billed or charged for ENBREL provided by this program. I understand that no free product should be sold, traded, or distributed for sale.

\_\_\_\_\_  
**Physician's Original Signature (stamps not accepted)**

\_\_\_\_\_  
**Date Signed**

*Completion of this form is independent of the application process and does not guarantee enrollment in the ENCourage Foundation®. The ENCourage Foundation® must review the complete application to determine the patient's eligibility.*