EMD Serono
Living science, transforming lives

EMD

EMD Serono Compassionate Care Program
6501 Weston Parkway
Suite 370
Cary, NC 27513

Dear Valued Customer:

Thank you for your interest us in the EMD Serono Compassionate Care Program. Please take the time to read and complete the attached forms. Once the forms are returned, we will rapidly review them and determine your eligibility.

As a reminder, please attach the following with your submission:

- EMD Serono Compassionate Care Enrollment Form
- EMD Serono Patient Authorization Form
- Income Verification Document(s)

Please return your form to by fax or mail to:

Compassionate Care Program
6501 Weston Parkway, Suite 370
Cary, NC 27513
Fax: (919) 415-2870

EMD Serono is committed to breaking down financial barriers for patients pursuing treatment. We wish you the best of luck in your journey.

Best regards,

EMD Serono Compassionate Care Program

Compassionate Care Program

2013 PATIENT ENROLLMENT FORM

Phone: (855) 541-5926 Fax: (919) 415-2870

PATIENT INFORMATION Please remember that your program eligibility requires that you promptly notify the Compassionate Care Program by calling (855) 541-5926 if you become insured by any private or government insurance plan.

FIRST NAME		LAST NAME	MI
DATE OF BIRTH	GENDER ❒ Male ❒ Female	By providing your email address, you consent to receive additional mailings from the Compassionate Care Program. E-MAIL	
HOME PHONE		MOBILE PHONE	
MAILING ADDRESS		CITY / STATE / ZIP CODE	
PREFERRED METHOD OF CONTACT ❒ Home Phone ❒ Mobile Phone ❒ Mail ❒ E-mail		COUNTRY	

If you're unavailable when we call, is it ok for us to leave a message, including the Compassionate Care Program name? ❒ Yes ❒ No

TREATMENT

Are you currently undergoing fertility treatment with a fertility specialist? ❒ Yes ❒ No

Have you ever received products through the Compassionate Care Program in the past? ❒ Yes ❒ No

I have been prescribed the following:

❒ Any Gonal-f® (follitropin alpha for injection) product ❒ Cetrotide (cetrorelix acetate for injection) ❒ Ovidrel (choriogonadatropin alfa for injection)

Fax or mail your income verification form to the Compassionate Care Program:
Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

We will need to know the annual adjusted gross income for the entire household. The following are acceptable income documents that we can use to validate your income:

- 1040 Form
- 1040 - A Form
- 1040 - EZ Form
- 1040 Form Married Filing Separately (MFS) Need a form from both filers
- 1040 - A Form (MFS)
- W2/1099R Form
- 1099 Form
- Pension Notification Letter
- Social Security Award Letter

How many people live in your household?

Patient Signature and Authorization:
Fax: (919) 415-2870 Mail: Compassionate Care Program • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the terms of this enrollment form and the attached Authorization to Use and Disclose health and other personal information.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____

PHYSICIAN CERTIFICATION

FIRST NAME Robert J Kutz, MD		SITE NAME Cny fertility Center	
ADDRESS 495 Thrapp Lane		CITY Syracuse / STATE NY	ZIP CODE 13205
PHONE 3154698200	FAX 3156715756	E-MAIL TRKunn@cnyfertility.com	

By signing below I certify that the therapy above is medically necessary and that I will supervise the patient's treatment accordingly. I agree to release the above information and other health and medical information to EMD Serono, its agents, and contracted dispensing pharmacies to assist the patient in obtaining coverage for select EMD Serono products.

PHYSICIAN SIGNATURE _____ DATE 2/7/13

For assistance or additional information, call (855) 541-5926 Monday - Friday, 8:00 AM - 8:00 PM EST

Authorization to Use and Disclose Health and Other Personal Information

Patient's Name _____

Address _____

Home Phone _____ DOB _____/_____/_____

I authorize my physician and his/her staff to disclose my health and other personal information, including, but not limited to, the information on this form, to EMD Serono, Inc. and its agents and representatives including any company that helps administer EMD Serono's Compassionate Care Program (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

(1) contact me by mail, e-mail, and/or telephone to enroll me in, and administer EMD Serono's Compassionate Care Program;

(2) provide me with materials relating to EMD Serono's Compassionate Care Program;

(3) verify the accuracy of the information I provide in my application for EMD Serono's Compassionate Care Program;

(4) conduct surveys to measure my satisfaction with EMD Serono's Compassionate Care Program; and

(5) for such other purposes as may be required or permitted by applicable law.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, there is no guarantee that it will not be disclosed to another third party. However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

PATIENT MUST SIGN THE BACK OF THIS FORM THEN SEND OR FAX BOTH PAGES

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Products, but it will limit my ability to participate in EMD Serono's Compassionate Care Program.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono or its representatives in writing by mail or fax at 6501 Weston Parkway, Suite 370, Cary, NC 27513, fax (919) 415-2870. If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____

Signature of patient (or personal representative): _____ Date: ___/___/_____

Authority/relationship of personal representative (if applicable): _____

Signature of patient (or personal representative): _____ Date: ___/___/_____

Authority/relationship of personal representative (if applicable): _____

PATIENT MUST SIGN THE BACK OF THIS FORM THEN SEND OR FAX BOTH PAGES