

Need help accessing funding for your medication?



We may be able to help

Your doctor has prescribed a Genzyme Oncology Product as part of your or your family member's cancer treatment. The maker of this product, Genzyme Canada, has developed a program to help people find financial assistance to pay for their medication. This program is run in partnership with Shoppers Drug Mart Specialty Health Network.

How does it work?

Your doctor may talk to you about options for financial assistance that may be available for the medication you have been prescribed. These options depend on where you live, whether you already have private coverage and other financial information.

What type of help can I get?

Depending on the amount of financial assistance you or your family needs, you may be able to get more coverage from your insurance company or help from government programs. This program will uncover all potential routes of reimbursement for the medication.

What information is included in the enrollment form?

The enrollment form contains:

- basic contact and funding coverage information
- clinical information regarding your condition and whether you have any allergies
- the prescription for the medication from the doctor
- information about the prescribing physician
- your consent (please see form for details)

How do I know if I qualify?

Once you agree to be registered in the Program, your doctor will submit your or your family member's information to the Program and you will be contacted by a representative from Shoppers Drug Mart Specialty Health Network. After your information has been reviewed, you will be notified as to whether or not you qualify for assistance.

What about privacy?

All of the information you provide is totally confidential and limited to what is necessary to provide you with the best possible routes for funding and if required dispensing and administering of your medication. It may be shared with insurance companies or your provincial health insurance program, to the extent necessary, to evaluate your funding options. Your doctor will also receive periodic reports on the status of the funding assessment process.

Notes:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....



GENZYME ONCOLOGY PATIENT REIMBURSEMENT ASSISTANCE PROGRAM

Please complete this form in its entirety and FAX to 1-866-694-2413. All information will be kept confidential and will be treated as per the consent statement below. Please call 1-888-760-6454 if you have any additional questions.

PATIENT INFORMATION

Last Name: _____
First Name: _____ Gender: M F
Date of Birth (MM/DD/YYYY): _____
Phone: _____
Alternate Phone: _____
Home Address: _____
City: _____ Province: _____
Postal Code: _____

COVERAGE INFORMATION

Do you have coverage under a private drug plan? Yes No
Do you have coverage under a spousal drug plan? Yes No
Do you have coverage under your Provincial Health Plan? Yes No
Provincial Health Card Number: _____

CLINICAL INFORMATION

DIAGNOSIS: _____

ALLERGIES: Yes No

PRESCRIBING PHYSICIAN INFORMATION

Last Name: _____ First Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: _____ Ext: _____ Fax: _____

PATIENT CONSENT

I confirm that the information I have provided in this application is complete and accurate. I understand that Shoppers Drug Mart Specialty Health Network Inc. ("SDM SHN") reserves the right at any time and without notice to modify the Specialty Drug Patient Referral Program (the "Program") including its eligibility criteria and any other aspects of the Program or to discontinue the Program and terminate assistance. The Program is delivered by SDM SHN, a provider of client-focused services and patient support programs.

I authorize SDM SHN and its agents to contact me in relation to this application and to obtain additional medical and personal information ("Information") from me, my prescribing physician, pharmacist, nurse, insurer, government agency, employer or other sources ("Parties") as necessary in relation to the purposes of both identifying and securing my best options for funding my medication and if required, effectively and safely dispensing and administering my medication. I authorize SDM SHN to keep my information in their files for the duration of the services and to share the Information with the Parties as necessary to provide coordination of services under this Program.

PATIENT SIGNATURE _____ DATE: (MM/DD/YYYY)
VERBAL AUTHORIZATION FROM PATIENT

HEALTHCARE PROFESSIONAL SIGNATURE _____ DATE: (MM/DD/YYYY)
(YES, REGISTER THE ABOVE PATIENT)

Rx


Patient Name: _____

Address: _____

Quantity: _____ Refills: _____

I authorize the Program to be my designated agent to forward this prescription by fax or other mode of delivery to the pharmacy chosen by the above-named patient. This prescription represents the original prescription drug order for the patient. The patient's chosen pharmacy is the only intended recipient for this prescription and there are no others. Any prior prescription for this patient is being cancelled and has been securely filed and will not be transmitted at another time.

PHYSICIAN SIGNATURE _____ LICENSE NUMBER _____ DATE: (MM/DD/YYYY)

	Docket Number: GGECLO 8808		AD/Designer: YL	Production: KL	APPROVAL	BY	DATE	CHANGES	Date: June 21, 2010 3:07 PM
			Copywriter: XX	Account: AK	Studio				Studio Artist: YL
			Ad Number:		AD/Design				Notes: Rebuild InDesign file 06/02/10
	Client: Genzyme	Flat Size: 8.5 x 11"	Proofreader						Layout P04
	Brand: Genzyme oncology	Finished Size: 8.5 x 11"	Production						Copy Deck 20
	Project: Reimbursement kit tear pad 2	Safety: 0.25"	Account						CYAN MAGENTA YELLOW BLACK
Language: English	Bleed: no bleed	Copywriter						SPECIAL SPECIAL SPECIAL	
		OUTPUT SCALE	100%						