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Cephalon Oncology Reimbursement Expertise

Trisenox® (arsenic trioxide) injection

Cephalon Oncology Reimbursement Expertise — TRISENOX® Patient Enrollment Form

Please complete this worksheet before calling the CORE Hotline at 1-866-261-7730
between the hours of 9 AM and 8 PM (EST), or fax 1-888-891-4924 or mail to PO Box 1052, San Bruno, CA 94066

Upon receipt of a completed form and release, a representative from the CORE Hotline will contact the physician.

PROVIDER INFORMATION

Physician name

Address City State Zip

Phone Fax Office contact

Provider tax ID DEA #

PATIENT INFORMATION

Name

Address City State Zip

Home phone

Contact name (if other than patient) Contact phone

PATIENT INSURANCE INFORMATION

Primary insured name Employer

Insurance company 1 Insurance phone

Group number Policy number Provider ID

Insurance company 2 Insurance phone

Group number Policy number Provider ID

Patient SS # - - DOB / /

Drug TRISENOX® (arsenic trioxide) Injection Diagnosis

Dosage

Clinical history

Failed therapies

I, [Print Patient Name] , hereby authorize any insurer, health maintenance organization, prepayment organization, health plan, public health authority, employer, hospital, physician or any other healthcare provider to disclose to Cephalon, Inc. and its agents and assignees, all medical records and information, financial and insurance records and information, as well as other personal identifying information, with respect to myself, for the purpose of my enrollment or participation in the CORE Program. I also authorize Cephalon and its agents or assignees to disclose all such records and information, whether provided by myself or any third party, to any of the persons or entities listed above for the purpose of my enrollment participation in the CORE Program. I understand that any such records or information that reveals my identity will not be used for any purpose other than that described above unless I have given written consent. I verify that the information provided in this application is complete and accurate. I understand that Cephalon reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I authorize Cephalon to use my Social Security number for identification purposes and record keeping. I have read, understand and agree to all of the above. This consent is valid until rescinded in writing and a photocopy or faxed copy may be used in place of the original.

Print patient name Patient signature Date

I represent that, to the best of my knowledge, the information contained in this application is complete and accurate. I understand that Cephalon reserves the right to modify or terminate this program at any time.

Print MD name MD signature Date

Cephalon® Oncology