

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

## TO APPLY FOR THE FOUNDATION:

- Read and complete the Patient Application Form
- Sign and date the Patient Certification and Consent Form
- Provide proof of income. You may submit any one of the following:
  - latest federal or state tax return
  - latest W-2 statement
  - SSDI/SSI award letter
  - bank statements (last 3 months showing income deposits)
  - pay stubs (last 2 pay stubs)
  - state program acceptance letter or card (e.g. ORSA)

If you do not have proof of income or there is no current household income (\$0), due to job loss or other circumstances, please complete one of the following forms:

- notorized income statement (form enclosed)
  - attestation form with two signatures (form enclosed)
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- Have your physician complete and sign the Product Prescription Form

## MAIL OR HAVE YOUR PHYSICIAN'S OFFICE FAX THE COMPLETED APPLICATION TO:

ENCourage Foundation®  
PO BOX 4133  
Gaithersburg, MD 20885-9901  
Fax: 888/508-8083

(Note that faxed copies of applications must be sent from the physician's office.)

Once we receive a completed application, both you and your physician will be notified of your eligibility. For any questions please call 800/282-7752, Monday through Friday, 8am to 8pm Eastern Time.

Sincerely,

ENCourage Foundation®

## PATIENT APPLICATION FORM

### Patient Information

Patient First Name:	Patient Last Name:		
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	U.S. Resident?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Annual Household Income: \$	Source of Income:		
# of Persons in Household:	Email Address:		
Primary Phone #:	Primary Phone # Type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		
Secondary Phone #:	Secondary Phone # Type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile		

### Patient Address Information

#### Mailing Address

Address:		
City:	State:	Zip Code:

#### Shipping Address *(PO Box is not accepted)*

<input type="checkbox"/> Check here if shipping address is the same as mailing address		
Address:		
City:	State:	Zip Code:

### Insurance Information

- I am insured *(please fill out all of the applicable insurance information below)*  
 I am uninsured

Primary Patient Insurance Policy	Secondary Patient Insurance Policy
Insurance Carrier Name:	Insurance Carrier Name:
Subscriber First Name:	Subscriber First Name:
Subscriber Last Name:	Subscriber Last Name:
<b>Medicare (A, B)</b>	<b>Medicare Part D (Prescription Drug Plan)</b>
Enrollment Status: <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending	Enrollment Status: <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending
Effective Date:	Effective Date:
Telephone: (     )	Telephone: (     )
<b>Medicaid</b>	
Enrollment Status: <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending	
Effective Date:	
Telephone: (     )	

### Physician Information

Physician First Name:	Physician Last Name:	
Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	

### For Internal Use Only

Foundation ID# :	Distributor ID# :
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## PATIENT CERTIFICATION AND CONSENT

Patient's Name: \_\_\_\_\_

- I would like to receive Enbrel® (etanercept) free of charge from the ENCourage Foundation®. I do not have, nor am I eligible for, any private or public health insurance other than that listed above. I do not have, nor am I eligible for, any other form of public assistance with my medical expenses.
- I certify that I will not request reimbursement from any insurance carrier or government health benefit program for any ENBREL I receive from the ENCourage Foundation®.
- I certify that the enclosed information is correct to the best of my knowledge. I understand that this information will not be used for any other purpose unless I give written consent, the government requires it, or the ENCourage Foundation® removes my name and any other identifying information.
- I understand that the ENCourage Foundation® may change or stop this program with respect to any patient, or in its entirety, at any time. I also understand that, although ENBREL may be given to me free of charge now, this does not mean I will be entitled to receive it free of charge indefinitely.
- I will not sell, trade, or distribute ENBREL given to me by the ENCourage Foundation®.
- I authorize my health care provider and my health plan(s) to provide my medical records and related information, including but not limited to my name, Social Security number, address, and date of birth, and financial information to the ENCourage Foundation®, Amgen and Pfizer, the marketers of ENBREL, their agents, and designees, so that they can obtain information about my insurance coverage and determine if I am eligible to receive ENBREL at no cost to me through the ENCourage Foundation®. I also authorize the Foundation, Amgen, Pfizer and their agents and designees to share my medical and other related information with each other and with my health care providers and health plan(s) for the purpose of facilitating my ability to receive ENBREL through the Foundation, and to contact me to seek my feedback on the services provided by the Foundation.
- Once my health information has been disclosed by my Provider and my health insurers, federal privacy laws may no longer protect the information from further disclosure. However, the ENCourage Foundation®, Amgen, and Pfizer agree to protect my information by using and disclosing it only for the purposes described above or as required by law. I understand that I do not have to sign this Authorization, but if I do not, I may have to pay for Enbrel myself. My health care providers and health plans will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this Authorization. I may revoke this Authorization at any time by mailing or faxing signed letters of revocation to the ENCourage Foundation® at PO BOX 4133, Gaithersburg, MD 20879-7808 or via fax at 888/ 508-8083. I am entitled to a copy of this Authorization. This Authorization expires ten (10) years from the date of my signature. A photocopy of this authorization will be as valid as the original.
- I understand that the ENCourage Foundation®, Amgen, Pfizer, or its agents or designees, may need to work with my social worker or other health care professional to case manage and coordinate care, including drug refills, on my behalf. I hereby grant authority to \_\_\_\_\_ (first/last name), \_\_\_\_\_ (relationship to patient) to act as my representative for the purpose of coordination of therapy in the ENCourage Foundation®.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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

ENCourage Foundation®  
PO BOX 4133  
Gaithersburg, MD 20878-7808  
Phone: 800/282-7752 Fax: 888/508-8083

## PRODUCT PRESCRIPTION FORM

**Physician Instructions:** Please complete and sign the form. Fax or mail the completed form to the address below:

ENcourage Foundation®  
 PO BOX 4133  
 Gaithersburg, MD 20885-9901  
 Phone: 800/282-7752 Fax: 888/508-8083

### Physician Information

Physician First Name:		Physician Last Name:	
Facility/Practice Name:		Facility/Practice Contact Name: (other than physician)	
Address: (PO Box is not accepted)			
City:	State:	Zip Code:	
Phone #:	State License #:	Email:	

### Patient Information

Patient First Name:		Patient Last Name:	
Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

### Prescribing Information for Enbrel® (etanercept)

Medication	Dose	Frequency	Check One	Shipping Schedule
ENBREL	50mg SureClick®	Once weekly	<input type="checkbox"/>	<u>New Enrollees/Step-down Dosing:</u> <ul style="list-style-type: none"> <li>One year supply from prescription written date.</li> <li>Shipment monthly for the first three months, then every three months for the remaining nine months.</li> </ul> <u>Re-enrollees:</u> <ul style="list-style-type: none"> <li>One year supply from prescription written date.</li> <li>Four shipments of three months supply each.</li> </ul>
		Twice weekly for 3 months; then once weekly ( <b>Step-down Dosing</b> )	<input type="checkbox"/>	
ENBREL	50mg Prefilled Syringe	Once weekly	<input type="checkbox"/>	
		Twice weekly for 3 months; then once weekly ( <b>Step-down Dosing</b> )	<input type="checkbox"/>	
ENBREL	25mg Vial	Once weekly	<input type="checkbox"/>	
		Twice weekly	<input type="checkbox"/>	
ENBREL	25mg Prefilled Syringe	Once weekly	<input type="checkbox"/>	
		Twice weekly	<input type="checkbox"/>	
ENBREL			<input type="checkbox"/>	

All product shipments are sent to the patient. If you would like to have product shipped to the Physician's office instead, please check here .  
 Prescription length is 12 months unless otherwise noted here: \_\_\_\_\_

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.

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

*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 and supporting documentation to determine the patient's eligibility.*

### For Internal Use Only

Case # :	Patient ID# :
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OPTIONAL: *Only use this form if you cannot provide proof of income documentation*

## NOTARIZED INCOME STATEMENT

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

My estimated annual household income currently is \$\_\_\_\_\_.  
(Please include dollar amount)

- \$\_\_\_\_\_ Social Security Disability Income (SSDI) (Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_)
- \$\_\_\_\_\_ Supplemental Security Income (SSI)
- \$\_\_\_\_\_ Aid from the Department of Public Welfare
- \$\_\_\_\_\_ Unemployment Benefits (From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_)
- \$\_\_\_\_\_ Workers Compensation Benefits (From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_)
- \$\_\_\_\_\_ Dividends, interest, or investment accounts
- \$\_\_\_\_\_ Employment (Myself and/or my spouse)
- \$\_\_\_\_\_ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household: \_\_\_\_\_

**YOU MUST HAVE THIS FORM NOTARIZED IN ORDER TO PREVENT A DELAY  
IN THE PROCESSING OF YOUR APPLICATION.**

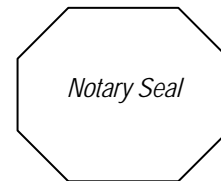
Patient Signature \_\_\_\_\_

Notary Seal

Date \_\_\_\_\_

Notary Signature \_\_\_\_\_

Date \_\_\_\_\_



OPTIONAL: *Only use this form if you cannot provide proof of income documentation*

## ATTESTATION FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

My estimated annual household income currently is \$\_\_\_\_\_.  
(Please include dollar amount)

- \$\_\_\_\_\_ Social Security Disability Income (SSDI) (Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_)
- \$\_\_\_\_\_ Supplemental Security Income (SSI)
- \$\_\_\_\_\_ Aid from the Department of Public Welfare
- \$\_\_\_\_\_ Unemployment Benefits (From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_)
- \$\_\_\_\_\_ Workers Compensation Benefits (From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_):
- \$\_\_\_\_\_ Dividends, interest, or investment accounts
- \$\_\_\_\_\_ Employment (Myself and/or my spouse)
- \$\_\_\_\_\_ Other (includes assistance from family, friends, charity, or church. Please specify the amount of financial assistance you receive - may include percentage of rent, food, etc.)

Number of People in Household: \_\_\_\_\_

**Patient Advocate/Physician Office Staff Attestation:**  
Physician office staff may sign below to attest to the patient's financial situation.

To the best of my knowledge, I know the financial information provided on this application to be true.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Original Signature: \_\_\_\_\_  
(Stamps not accepted)

Date: \_\_\_\_\_

### Patient Signature

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_