

Commitment to Care

The Commitment to Care program is designed to ensure that eligible individuals, including Medicare beneficiaries who meet our criteria, have access to Schering-Plough's cancer and hepatitis drugs. These medicines include:

- **PEGINTRON** (peginterferon alfa-2b) Powder for Injection
- REBETOL (ribavirin, USP) Capsules
- **INTRON A** (Interferon alfa-2b, recombinant) for Injection
- **TEMODAR** (temozolomide) Capsules
- TICE BCG, BCG LIVE (for intravesical use)
- NOXAFIL (posaconazole) Oral Suspension

The Commitment to Care program's reimbursement specialists provide eligible patients with all aspects of reimbursement assistance at no cost, including:

- insurance verification,
- pre-authorization or pre-certification,
- denial appeals, and
- referrals to state and local assistance programs.

In addition, the program distributed pharmaceutical products free of charge to more than 6,700 needy patients in 2008.

Unlike many other reimbursement programs, Commitment to Care is telephone based, offers patients easy access to a reimbursement assistance specialist with rapid follow up, and eliminates extensive paperwork.

To find out more about the Commitment to Care program, call toll free: 1-800-521-7157.

- [Commitment to Care Application](#) (29kb)
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MAIL OR FAX COMPLETED FORM TO THE SCHERING-PLOUGH COMMITMENT TO CARE® PROGRAM

IF YOU HAVE ANY QUESTIONS CALL: (800) 521-7157

For oncology/anti-fungals (option 1):

COMMITMENT TO CARE®

c/o AccessMed

6900 College Blvd. Suite 1000

Overland Park, KS 66211

Fax: (866) 277-9328

For hepatitis (option 2):

COMMITMENT TO CARE®

c/o AccessMed

6900 College Blvd. Suite 1000

Overland Park, KS 66211

Fax: (800) 683-7855

Please include the following documentation when submitting this application for consideration into the Schering-Plough COMMITMENT TO CARE® Program:

- Medicaid eligibility denial letter (if applicable)
- Copies of insurance cards front and back (if applicable)
- For requests other than benefits investigations, also provide proof of **household** monthly gross income in one of the forms listed below:
 - W-2s or last year's 1040 tax return (if not available, please provide one of the following):
 - Checking account statements (3 months worth)
 - Pay stubs (full month's worth of recent pay stubs, indicating payments year-to-date)
 - Social security benefit award letter
 - If zero income:
 - Notarized letter of support and zero income from family or
 - Zero income letter from physician, including explanation of how patient is supported

COMMITMENT TO CARE® APPLICATION

PATIENT INFORMATION - PLEASE PRINT

| | | | |
|---|-------------------------|---|--|
| Patient name: | | Social security #: | |
| | | Date of birth: | |
| Address: | | | |
| City: | State: | ZIP: | |
| Sex: | Phone number: | | |
| Prescribed Medication: | Diagnosis (ICD 9 code): | | |
| Marital status: | Household size: | | |
| Total household monthly gross income: \$ _____ MUST PROVIDE PROOF OF INCOME, SEE LIST ABOVE | | Amount patient has spent on patient's own prescription medications so far this year: \$ _____ | |

Are you covered by Medicare?: Yes No

May we contact the Centers for Medicare & Medicaid Services to verify your Medicare status?: Yes No

Have you applied for the Medicare Part D Low Income Subsidy? Yes No Pending

Date application was submitted: _____ If not eligible, reason for denial: _____

STATE PROGRAM INFORMATION

| | |
|--|--|
| <p style="text-align: center;">MEDICAID</p> <p>Have you applied?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending</p> <p>Date application was submitted: _____</p> <p>If not eligible, reason for denial: _____</p> | <p style="text-align: center;">OTHER STATE PROGRAMS</p> <p>Have you applied?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending</p> <p>Date application was submitted: _____</p> <p>If not eligible, reason for denial: _____</p> |
|--|--|

INSURANCE INFORMATION - PLEASE INCLUDE COPY OF CARD (FRONT AND BACK)

Please check the box if this request is for a benefits investigation only:

PRIMARY CARRIER NAME:

Telephone number:

Name of policy holder with date of birth:

Policy Id #:

Group #:

SECONDARY CARRIER NAME:

Telephone number:

Name of policy holder with date of birth:

Policy Id #:

Group #:

OTHER CARRIER NAME: (IE, VA, RAILROAD RETIREMENT)

Telephone number:

Name of policy holder with date of birth:

Policy Id #:

Group #:

HEALTH CARE PROVIDER INFORMATION

Is this patient currently on therapy using the Schering-Plough medication(s) in question? Yes No

Practice name:

Tax ID #:

State license #:

Prescriber name:

BCBS provider #:

Medicaid provider # w/PIN:

Address:

National provider identifier (NPI):

City:

State:

ZIP:

Telephone number:

Fax number:

Office contact person:

Patient Acknowledgment and Consent

The COMMITMENT TO CARE[®] program is a service of Schering Corporation. Collection of certain insurance, financial, and medical information is necessary in order to evaluate your enrollment into the program and, if enrolled, to provide you program services. The program services include verifying your insurance benefits, identifying potential alternative benefits for which you may be eligible, and/or evaluating you for participation in the COMMITMENT TO CARE[®] program. Except as discussed below, and except as permitted or required by law, this private medical, insurance, and financial information will be kept confidential and will not be shared with any third parties. Your information may be shared or disclosed in order to fully evaluate you for initial and continued enrollment in the program. For example, personal information may also be shared with physicians and health insurers in order to provide you with program services. In addition, we are required to report certain personal information to Schering Corporation in order to comply with FDA reporting requirements. Finally, nonidentifiable information from all program participants may be summarized for statistical or other purposes, but your identity cannot be determined from this summary information. By enrolling in COMMITMENT TO CARE[®], you are agreeing to this acknowledgment and consent.

Patient Name (please print) _____

Patient Signature _____ **Date** _____

Legal Representative/Guardian Signature _____ **Date** _____
(if applicable)