<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Manufacturer</th>
<th>Program Name</th>
<th>Website</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>Covered Medications</th>
<th>Eligibility Requirements</th>
<th>Application Process</th>
<th>Program Details</th>
<th>Application</th>
<th>Treatment Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abraxane</td>
<td>Paclitaxel Albumin-stabilized Nanoparticle Formulation</td>
<td>Abraxis Oncology</td>
<td>ARC of Support</td>
<td><a href="http://abraxane.com/patienthelp/insurance_payment_support.html">http://abraxane.com/patienthelp/insurance_payment_support.html</a></td>
<td>PO Box 230548</td>
<td>(800)564-0216; option 3</td>
<td>(866)242-4141</td>
<td>Abraxane injection 100mg (paclitaxel protein-bound particles)</td>
<td>The patient must be a U.S. citizen that has no insurance and meets income guidelines.</td>
<td>The application can be downloaded from Abraxane.com or can be requested via telephone. The form must be completed by the patient and their doctor, and can be submitted by fax or regular mail. Eligibility determination is usually made within 2-3 business days, and the patient’s doctor is notified of the patient’s eligibility. If the patient is deemed eligible, the medication is shipped within 3-5 business days.</td>
<td>Once a patient’s eligibility has been determined, up to a 30-day supply is sent to the patient’s doctor’s office, with automatic refills. A new application is required every 6 months and a new application with full documentation is required every 12 months.</td>
<td><a href="http://abraxane.com/patienthelp/insurance_payment_support.html">http://abraxane.com/patienthelp/insurance_payment_support.html</a></td>
<td>Metastatic and recurrent breast cancer.</td>
</tr>
<tr>
<td>Adagen</td>
<td>Pegademase</td>
<td>Enzon</td>
<td>Enzon Patient Assistance Program</td>
<td><a href="http://www.enzon.com/">http://www.enzon.com/</a></td>
<td>750 Century Center Parkway, Suite 109, Memphis, TN 38134</td>
<td>(866)242-4141</td>
<td>option 5</td>
<td>Adagen injection, Oncaspar, Depocyt</td>
<td>The patient must be a U.S. resident; have no prescription coverage (commercial, government or special services); for the medication, have an income at or below $25,000 if single ($40,000 for a family); provide proof of application and denial from the State Medicaid program; and have insufficient out-of-pocket financial resources. Patients who eligible for Medicare, Part D but did not enrolled may still be eligible for this program.</td>
<td>The application or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. Eligibility notification will be sent to whomever submitted the application. The eligibility determination is usually made within 3-5 business days. Once the determination is made, the medication is shipped the next day.</td>
<td>Once a patient’s eligibility has been determined, the medication will sent to either the doctor’s office, or a specific site (clinic, Hospital, infusion site etc.) in the amount requested. A new prescription is required for each refill, and a new application with full documentation is required every 12 months.</td>
<td>Enzon Patient Assistance Program</td>
<td>Replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined Immunodeficiency disease (SCID) who are not suitable candidates or for who have failed bone marrow transplantation.</td>
</tr>
<tr>
<td>Adrucil</td>
<td>Fludarabine, S-FU</td>
<td>TEVA Pharmaceuticals</td>
<td>TEVA Assistance Program</td>
<td>N/A</td>
<td>PO Box 62028</td>
<td>(877)354-1039</td>
<td>(888)725-5198</td>
<td>Adrucil injection 250mg, Adrucil injection 500mg, Adrucil injection 100mg</td>
<td>The patient must be a U.S. resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program.</td>
<td>The patient’s doctor must call to request the application, which will then be sent to the doctor’s office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.</td>
<td>The patient’s doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor’s office. It is the doctor’s responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.</td>
<td>TEVA Assistance Program</td>
<td>Palliative management of carcinoma of the colon, rectum, breast, stomach and pancreas.</td>
</tr>
<tr>
<td>Aldara</td>
<td>Imiquimod</td>
<td>Graceway Pharmaceuticals</td>
<td>Graceway Pharmaceutical Patient Assistance Program</td>
<td><a href="http://www.graceway.com/%E9%95%BF%E6%B2%99">http://www.graceway.com/长沙</a> (m/patient/helpful/resources/insurance_support/insurance_payment_support.html)</td>
<td>PO Box 8302</td>
<td>(866)838-8408; (888)838-5820</td>
<td>Aldara Cream</td>
<td>The patient must be a U.S. resident; have no public or private prescription insurance, and have an income at or below 200% of the Federal Poverty Level.</td>
<td>The application can be requested by telephone and must be completed by the patient and the doctor. The completed application must be submitted by mail. Both the patient and doctor will be notified of the eligibility determination.</td>
<td>The application can be requested by telephone and must be completed by the patient and their doctor. The completed application must be submitted by mail. Both the patient and doctor will be notified of the eligibility determination.</td>
<td>Upon eligibility determination, up to a 90-day supply will be sent to the doctor’s office. A new application and prescription are required for refills. A new application with full documentation is required every 12 months.</td>
<td>Aldara Patient Assistance Program</td>
<td>Superficial basal cell carcinoma (skin cancer).</td>
</tr>
</tbody>
</table>
Once eligibility has been determined, the doctor can request the application by phone, and will receive it by fax. The application must be completed by the patient and the doctor and must be submitted by fax.

Once eligibility has been determined, the medication will be sent to the doctor's office. The doctor must fill out a replacement form to obtain refills. A new application is required every 12 months.

Approved by the FDA to treat malignant pleural mesothelioma in some patients. It is also approved to treat non-small cell lung cancer that is advanced or has metastasized (spread) in patients who have already had other chemotherapy.

Aranesp is indicated for the treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis and for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy.

Aredia is indicated for the treatment of moderate or severe hypercalcemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis and for the treatment of Paget's disease of bone. Aredia therapy has also been effective in reducing these biochemical markers in patients with Paget's disease who failed to respond, or no longer responded to other treatments. Osteolytic Bone Metastases of Breast Cancer and Osteolytic Lesions of Multiple Myeloma Aredia is indicated, in conjunction with standard antineoplastic therapy, for the treatment of osteolytic bone metastases of breast cancer and osteolytic lesions of multiple varieties of multiple.
<table>
<thead>
<tr>
<th><strong>Arimidex</strong></th>
<th><strong>Anastrozole</strong></th>
<th><strong>AstraZeneca Cancer Support Network (AZ CSN)</strong></th>
<th><strong><a href="http://www.astrazeneca-us.com/content/patientAssistance/patientAssistanceProgram/astrazeneca-how-to-apply.asp?id=">http://www.astrazeneca-us.com/content/patientAssistance/patientAssistanceProgram/astrazeneca-how-to-apply.asp?id=</a></strong></th>
<th><strong>PO Box 66551 St. Louis, MO 63166-6551</strong></th>
<th><strong>(866)992-9276</strong></th>
<th><strong>N/A</strong></th>
<th><strong>Arimidex tablets 1mg Faslodex injection 2.5 ml Zoladex depot 3.6 mg (monthly) Zoladex depot 10.8 mg (every 3 months)</strong></th>
<th><strong>The patient must: be a US Resident or have a valid visa; not have prescription insurance; be ineligible for any government programs; and have an income at or below 250% of the Federal Poverty Level. Patients who are eligible for Medicare Part D but have not enrolled may still eligible for this program. The prescription may be downloaded from the website or requested by telephone. If requested by telephone, the requester will receive the application by fax. The patient and their doctor must complete the application and submit it by mail. If a patient is determined ineligible, both the patient and doctor will be notified. Delivery of medication may take 3-5 weeks. Once eligibility has been determined, a 90-day supply will be sent to the doctor. The patient or their doctor must contact the program for refills. A new application with documentation is required every 12 months.</strong></th>
<th><strong><a href="http://www.astrazeneca-us.com/content/patientAssistance/patientAssistanceProgram/pdf/243041%20PAP%20English.pdf">http://www.astrazeneca-us.com/content/patientAssistance/patientAssistanceProgram/pdf/243041%20PAP%20English.pdf</a></strong></th>
<th><strong>Approved by the FDA to be used alone or together with other treatments for breast cancer in postmenopausal women.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AZ Medicine and Me</strong></td>
<td><strong><a href="http://www.astrazeneca-us.com/content/patientAssistance/astrazeneca-medicine-and-me.asp?id=">http://www.astrazeneca-us.com/content/patientAssistance/astrazeneca-medicine-and-me.asp?id=</a></strong></td>
<td><strong>N/A</strong></td>
<td><strong>(800)957-6285</strong></td>
<td><strong>N/A</strong></td>
<td><strong>Arimidex tablets 1mg Faslodex injection 5 ml Zoladex depot 10.8 mg (every 3 months)</strong></td>
<td><strong>The patient must be enrolled in Medicare Part D, and have an income below $30,000 for an individual (below $40,000 for a couple.) The patient must have spent at least 3% of the annual household income on prescription drugs during the calendar year. The patient must call for a prescreening; during with eligibility determination will be made. Delivery of medication may take 3-5 weeks. Once eligibility has been determined, a 90-day supply will be sent to the doctor. The patient or their doctor must contact the program for refills. A new application with documentation is required every 12 months.</strong></td>
<td><strong><a href="http://www.astrazeneca-us.com/content/patientAssistance/astrazeneca-medicine-and-me.asp?id=">http://www.astrazeneca-us.com/content/patientAssistance/astrazeneca-medicine-and-me.asp?id=</a></strong></td>
<td><strong>Approved by the FDA to be used alone or together with other treatments for breast cancer in postmenopausal women.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aromasin</td>
<td>Exemestane</td>
<td>Pfizer, Inc.</td>
<td>Pfizer Pfizers</td>
<td><a href="http://www.commitmenttoaccess.com/">http://www.commitmenttoaccess.com/</a></td>
<td>PO Box 10241</td>
<td>Trenton, NJ 08690-9024</td>
<td>866-909-2800</td>
<td>N/A</td>
<td>Aromasin tablet 25mg</td>
<td>Celebrex capsules 100 mg</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| The patient is issued a pharmacy card to be used once per month. This is a discount program. The application can be downloaded from the program's website or can be requested by telephone. If requested by telephone, the request will receive the application by fax. The patient and their doctor must submit the form and meet income guidelines. Patients who are eligible for Medicare Part D but have no prescription coverage for the medication; and have an income at or below 350% of the Federal Poverty Level. The patient must: be a US resident; have no prescription coverage for the medication; and meet income guidelines. The application can be downloaded from the program's website or can be requested by telephone, or can be started online. The patient and their doctor must complete the application. If requested by telephone, the application will be faxed or mailed to the patient and their doctor. The patient and their doctor must complete the application and can submit it by fax or mail. The patient and doctor are notified in writing of the eligibility determination. The determinations are usually made within 48 hours. If the patient is deemed eligible, the medication will be shipped out within 5-7 business days. Upon eligibility determination, a 30-day supply will be sent to the patient's home. The program will contact the patient's doctor to arrange for refills. A new application with documentation must be submitted every 12 months. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen. Approved by the Food and Drug Administration (FDA) to treat advanced breast cancer and to prevent recurrent breast cancer. It is used in postmenopausal women who have already been treated with tamoxifen.
Aavistin
Genentech, Inc.
Access to Care Foundation
https://www.spocomline.com/spocomline/portal/channel.jsp
1 DNA Way, Mail Stop 210 South San Francisco, CA 94080
(800)530-3083
(866)225-1366
Aavistin, Herceptin, Rituxan, Tarceva

The eligibility guidelines for this program are not disclosed. If the patient is eligible for Part D but does not enroll then s/he may be eligible for this program.

The patient’s doctor can request an application by telephone and must verify the patient’s financial circumstances.

This is a drug replacement program. The medication will be sent to the patient’s doctor.

N/A

Approved by the FDA to be used with other drugs to treat colorectal cancer that has spread to other parts of the body. Bevacizumab is also approved to be used with other drugs to treat non-small cell lung cancer that cannot be removed by surgery, has spread to other parts of the body, or has recurred.

N/A

Approved by the FDA to be used with other drugs to treat colorectal cancer that has spread to other parts of the body. Bevacizumab is also approved to be used with other drugs to treat non-small cell lung cancer that cannot be removed by surgery, has spread to other parts of the body, or has recurred.

N/A

N/A

Bexxar
Youxibumab 131 tositumomab
GlaxoSmithKline
GlaxoSmithKline Commitment to Access
http://www.commitmenttoaccess.com
PO Box 29038
Phoenix, AZ 85038-2938
(866)265-6491
N/A

Antronon injection
Bexxar injection 14mg/ml
Hycamtin injection 4mg/ml
Leukeran tablets 2mg
Myleran tablets 2mg

The patient must: be a US resident; have no prescription coverage for the medication; and have an income at or below 350% of the Federal Poverty Level. GlaxoSmithKline requests that an “Advocate” be the contact person for the patient throughout the entire process. The advocate can be any healthcare worker involved in the patient’s care (i.e., doctor, nurse, social worker, or someone in the healthcare office or facility). The application needs a total of 3 signatures; doctor, patient and advocate. If the patient chooses not to enroll in Medicare Part D, then they are eligible to be on this program. Each application must have a unique patient id number.

The patient can be requested by telephone, or can be started online. If requested by telephone, the application will be faxed or mailed to the patient advocate or patient. The patient and their doctor must complete the application. Once completed, the patient advocate must call for a phone screening, and then they must submit the application by mail. Notification of eligibility determination is sent to whomever started the application process.

Upon eligibility determination, a 30-day supply will be sent to the patient’s doctor. It is the doctor’s responsibility to contact the program to arrange for refills. A new application is required every 12 months.

N/A

Approved by the FDA for the treatment of patients with CDOO positive, follicular, non-Hodgkin’s lymphoma, with and without transformation, whose disease is refractory to Rituximab and has recurred following chemotherapy.

N/A

Approved by the FDA as a single agent or in established combination therapy with other approved chemotherapeutic agents in the following: 1. Brain tumors—glioblastoma, brainstem glioma, medulloblastoma, astrocytoma, ependymoma, and metastatic brain tumors. 2. Multiple myeloma—in combination with prednisone. 3. Hodgkin’s Disease—as secondary therapy in combination with prednisone. 3. Hodgkin’s Disease—as secondary therapy in combination with prednisone.
Lymphomas— as secondary therapy in combination with other approved drugs for patients who relapse while being treated with primary therapy, or who fail to respond to primary therapy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Manufacturer</th>
<th>Website</th>
<th>Address</th>
<th>Phone</th>
<th>Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blenoxane</td>
<td>Bedford Laboratories</td>
<td><a href="http://www.bedfordlabs.com/index">http://www.bedfordlabs.com/index</a></td>
<td>300 Northfield Rd</td>
<td>Bedford, OH 44146</td>
<td>(440)332-5284</td>
</tr>
<tr>
<td>Blomycin injection 4ml</td>
<td>Daunorubicin injection 20mg/4ml</td>
<td>Dacarbazine injection 200 mg</td>
<td>Cisplatin injection 50mg/ml</td>
<td>Doxorubicin injection 1mg</td>
<td>Decisions are made on a case-by-case basis. The patient’s doctor must submit a letter on letterhead stating their patient’s need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative. N/A N/A</td>
</tr>
<tr>
<td>Enbrel</td>
<td>Enbrel Laboratories</td>
<td><a href="http://www.enbrel.com">http://www.enbrel.com</a></td>
<td>300 Northfield Rd</td>
<td>Bedford, OH 44146</td>
<td>(800)321-4669</td>
</tr>
</tbody>
</table>

N/A N/A Approved by the FDA as a palliative treatment. It has been shown to be useful in the management of the following neoplasms either as a single agent or in proven combinations with other approved chemotherapeutic agents: Squamous Cell Carcinoma Head and neck (including mouth, tongue, tonsil, nasopharynx, oropharynx, sinus, palate, lip, bucal mucosa, gingivae, epulis, skin, larynx), penis, cervix, and vulva. The response to this medication is poorer in patients with previously irradiated head and neck cancer, such as Lymphomas Hodgkin’s Disease, non-Hodgkin’s lymphoma, Testicular Carcinoma Embryonal cell, chorioncarcinoma, and teratocarcinoma. This medication has also been shown to be useful in the management of Malignant Pleural Effusion and prevention of Recurrent Pleural Effusion.

N/A N/A Approved by the FDA for the treatment of B-cell chronic lymphocytic leukemia (B-CLL) in patients who have been treated with alkylating agents and who have failed fludarabine therapy.
Camptosar
Eli Lilly
Pfizer, Inc.
First Resource Program for IV Medications
http://www.pfizerhelpfulanswers.com/ProgramList.aspx
PO Box 330
San Bruno, CA 94066-0339
(877)744-5675

Camptosar injection 5ml
Ellence solution 50 mg/35 ml
Irinotecan injection 500mg
Zinadex powder for injection
Zinadex powder for injection 250mg/ml

The patient must: be a US resident, have no prescription coverage for the medication, and meet undisclosed income guidelines. Patients who are eligible for Medicare Part D but who have not already enrolled may still be eligible for participation in this program.

The doctor, patient, social worker or patient advocate must call for a preapproval. The application is sent to either the doctor or patient depending on the medication requested. The patient and their doctor must complete the application and submit it by fax or mail. The doctor will be notified of the eligibility determination, which is usually made within 48 hours.

Once eligibility is determined, the medication will be sent to the doctor's office. A refill request form is included with each shipment and must be completed and submitted to receive a refill. A new application is required every 6 months.

Upon eligibility determination, up to a 30-day supply will be sent to the patient's doctor's office. The program will contact the doctor to arrange for refills. A new application with documentation is required every 12 months.

The FDA has approved this drug, and found it to be useful as a single agent in addition to other treatment modalities, or in established combination therapy with other approved chemotherapeutic agents in the following: Brain tumors: both primary and metastatic, in patients who have already received appropriate surgical and/or radiotherapeutic procedures. Hodgkin's Disease: secondary therapy in combination with other approved drugs approved 'Donut Hole.'

The patient must not have any private or public insurance and cannot afford the co-pay, or is in extreme hardship, they could receive assistance, and should contact the program for more information.

The form may be downloaded for the website, or may be requested by telephone. If requested by telephone, it will be sent by fax. The patient and their doctor must complete the application and submit it by mail. Both the patient and their doctor will be notified of the eligibility determination in writing. Allow 4 weeks for application processing and medication delivery.

Upon determination of eligibility, up to a 90-day supply of medication will be sent to the patient's doctor. The patient can send in a new application for a refill, or the patient's doctor can fill in a refill. A new application is required each year.

N/A
Approved by the FDA for the treatment of patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed following 5-FU-based therapy.
TEVA Assistance

Approved by the FDA for the treatment of metastatic malignant melanoma, and is also indicated for Hodgkin's disease as a secondary-line therapy when used in combination with other effective agents.

The patient's doctor must call to request the application, which will then be sent to the doctor's office. The doctor must be a US resident; have no prescription coverage for the medication; and meet income guidelines that are not disclosed.

Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request referrals when they are needed. A new application is required every 6 months.

Cosmegen

Ovation Pharmaceutical’s Patient Assistance Program

http://www.ovationpharma.com/prod/cust_reim.htm

The program is based on undisclosed guidelines. This program also has a Reimbursement Support component to aid with insurance coverage issues and can refer patients for co-payment assistance.

Cosmegen powder for injection

Mustargen powder for injection

Decitabine

MGI Pharma, Inc.

Decitabine injection 50 mg

Decitabine Dacitnomycin Ovation

Decitabine is indicated for Hodgkin's disease as a secondary-line therapy.

Decitabine is also indicated for nonseminomatous germ-cell tumors.

Decitabine is also indicated for relapsed/refractory myelodysplastic syndromes (MDS).

Decisions are made on a case-by-case basis.

The patient's doctor must submit a letter on their prescription coverage, which will be faxed to the doctor. The patient and their doctor must complete the application and submit by fax or mail. The eligibility determination will be sent to the patient's doctor, who must contact the program to arrange for refills. A new application is required every 12 months.

Once the eligibility determination has been made, the medication will be sent to the patient's doctor. It is the doctor's responsibility to contact the program to request referrals when they are needed. A new application is required every 12 months.

Daunorubicin

Daunomycin Bedford Laboratories

Daunorubicin daunomycin Bedford Laboratories

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Daunorubicin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and

Decitabine injection 50 mg

Bleomycin injection 5mg

Bleomycin is also indicated for non-Hodgkin's lymphoma (lymphogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and
TEVA Assistance Program

TEVA Assistance Program is approved by the FDA in combination with other approved anticancer drug therapy for nonlymphomatous leukemia/myelogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and adults.

Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

The patient's doctor must: be a U.S. resident; have no prescription coverage or have reached their income cap and meet undisclosed guidelines. There are no controlled trials that demonstrate a clinical benefit resulting from this treatment, such as improvement in disease-related symptoms, or increased time to disease progression, or increased survival.

Approved by the FDA for the treatment of AIDS-related Kaposis's sarcoma in patients with disease that has progressed on prior combination chemotherapy or in patients who are intolerant to such therapy.

The patient must: have no prescription coverage or have reached their income cap and meet undisclosed guidelines. There are no controlled trials that demonstrate a clinical benefit resulting from this treatment, such as improvement in disease-related symptoms, or increased time to disease progression, or increased survival.

Approved by the FDA in combination with other approved anticancer drug therapy for nonlymphomatous leukemia/myelogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and adults.

The patient's doctor must call to request refills when they are needed. A new application is required every 6 months.

The patient or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

The application can be downloaded or requested by telephone. If requested by telephone, the application will be faxed to the recipient. The patient and their doctor must complete the application and submit it by fax or mail. The patient's doctor will be notified of the eligibility determination. Upon eligibility determination the medications will be sent to the doctor, or a pharmacy card will be sent to the patient. The program will contact the doctor to arrange refills. A new application with full documentation is required every 12 months.

The patient must complete the application and submit by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

The patient or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. Eligibility notification will be sent to whomever submitted the application. The eligibility determination is usually made within 3-5 business days. Once the determination is made, the medication is shipped the next day.

The patient must: be a U.S. resident; have no prescription coverage or have reached their income cap and meet undisclosed guidelines. There are no controlled trials that demonstrate a clinical benefit resulting from this treatment, such as improvement in disease-related symptoms, or increased time to disease progression, or increased survival.

The patient must complete the application and submit by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program.

The patient's doctor must complete the application and submit by fax or regular mail. The patient's doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor, or a pharmacy card will be sent to the patient. The program will contact the doctor to arrange refills. A new application with full documentation is required every 12 months.

The patient or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. Eligibility notification will be sent to whomever submitted the application. The eligibility determination is usually made within 3-5 business days. Once the determination is made, the medication is shipped the next day.

The patient must: have no prescription coverage or have reached their income cap and meet undisclosed guidelines. There are no controlled trials that demonstrate a clinical benefit resulting from this treatment, such as improvement in disease-related symptoms, or increased time to disease progression, or increased survival.

Adrucil injection 2.5gm
Adrucil injection 500gm
Daunorubicin injection 20mg
Daunorubicin injection 50mg
Dacarbazine Injection 200 mg
Dacarbazine Injection 500 mg
Daunorubicin injection 50mg
Doxil Doxorubicin Liposomal Ortho Biotech Products, L.P.

PROCRITline http://www.doxilinetrino.jsp

DAVA Pharmaceuticals

DAVA Pharmaceuticals is approved by the FDA in combination with other approved anticancer drug therapy for nonlymphomatous leukemia/myelogenous, monocytic, erythroid) of adults and for remission induction in acute lymphocytic leukemia of children and adults.

The application can be downloaded or requested by telephone. If requested by telephone, the application will be faxed to the recipient. The patient and their doctor must complete the application and submit it by fax or mail. The patient's doctor will be notified of the eligibility determination. Upon eligibility determination the medications will be sent to the doctor, or a pharmacy card will be sent to the patient. The program will contact the doctor to arrange refills. A new application with full documentation is required every 12 months.

The patient or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. Eligibility notification will be sent to whomever submitted the application. The eligibility determination is usually made within 3-5 business days. Once the determination is made, the medication is shipped the next day.

The patient must: have no prescription coverage or have reached their income cap and meet undisclosed guidelines. There are no controlled trials that demonstrate a clinical benefit resulting from this treatment, such as improvement in disease-related symptoms, or increased time to disease progression, or increased survival.

The patient or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. Eligibility notification will be sent to whomever submitted the application. The eligibility determination is usually made within 3-5 business days. Once the determination is made, the medication is shipped the next day.

The patient must: be a U.S. resident; have no prescription coverage (commercial, government or special services) for the medication; have an income at or below $25,000 if single ($40,000 for a family); provide proof of application and denial from the State Medicaid program; and have insufficient out-of-pocket financial resources. Patients who eligible for Medicare, Part D but did not enrolled may still be eligible for this program.

The patient or doctor can request the application by telephone. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. Eligibility notification will be sent to whomever submitted the application. The eligibility determination is usually made within 3-5 business days. Once the determination is made, the medication is shipped the next day.
Approved by the FDA for the treatment of metastatic malignant melanoma, and is also indicated for Hodgkin's disease as a secondary-line therapy when used in combination with other effective agents.

Decisions are made on a case-by-case basis. When used in combination with other effective and attach a prescription.

(440)232-6264 Bleomycin injection 5ml

Alternatively, they may provide their information to their drug representative.

(800)562-4797, option 2

http://www.bedfordlabs.com/index

300 Northfield Rd. Bedford, OH 44146

DTIC-Dome

Bedford Laboratories

Eligard Leuprolide Acetate TEVA Pharmaceuticalis

Eligard TEVA Assistance Program

Eligard

Chadwick

SCLC Program

Chadwick Pharmaceuticals

SCLC

Approved by the FDA for the palliative treatment of advanced prostate cancer.

Approved by the FDA for the treatment of metastatic malignant melanoma, and is also indicated for Hodgkin's disease as a secondary-line therapy when used in combination with other effective agents.

Diagnoses are made on a case-by-case basis. The patient's doctor must submit a letter on letterhead stating their patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative.

N/A

N/A

N/A

N/A

N/A

The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program.

The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

Eligard

Leuprolide Acetate TEVA Pharmaceuticalis

Eligard TEVA Assistance Program

Eligard

Chadwick

SCLC Program

Chadwick Pharmaceuticals

SCLC

Approved by the FDA for the initial management of plasma uric acid levels in pediatric patients with leukemia, lymphoma, and solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis and subsequent elevation of plasma uric acid.

The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

Scleroderma

Nasofunctional

Nasofunctional TEVA Assistance Program

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional

Nasofunctional
Approved by the FDA to treat early-stage breast cancer that has spread to the lymph nodes under the arm. It is used together with other chemotherapy after breast cancer surgery.

N/A Approved by the FDA to treat early-stage breast cancer that has spread to the lymph nodes under the arm. It is used together with other chemotherapy after breast cancer surgery.
<table>
<thead>
<tr>
<th>Brand</th>
<th>Manufacturer</th>
<th>Participant</th>
<th>Enrollment</th>
<th>Discount Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Merck Prescription Discount Program</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/medicarebenefits/about.html">http://www.merck.com/medicarebenefits/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 499</td>
<td>19044</td>
<td>(800)506-3725</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Parsippany, NJ 07054</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/merckhelps/uninsured/about.html">http://www.merck.com/merckhelps/uninsured/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 369</td>
<td>90546-0369</td>
<td>(888)726-6436</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Harleysville, PA 19438</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/merckhelps/uninsured/about.html">http://www.merck.com/merckhelps/uninsured/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 13185</td>
<td>92039</td>
<td>(888)726-6436</td>
<td>(877)727-2867</td>
</tr>
<tr>
<td></td>
<td>La Jolla, CA 92039</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/medicarebenefits/about.html">http://www.merck.com/medicarebenefits/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 991</td>
<td>92039</td>
<td>(800)736-0003</td>
<td>(866)694-2545</td>
</tr>
<tr>
<td></td>
<td>Somerville, NJ 08876</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/medicarebenefits/about.html">http://www.merck.com/medicarebenefits/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 991</td>
<td>90546</td>
<td>(888)735-3725</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Parsippany, NJ 07054</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The patient must be a US resident, have a prescription from a US doctor, and have no insurance. The application can be downloaded from the website or requested by phone. If requested by phone, the application will be faxed to the recipient. The application must be completed by the patient and their doctor and then submitted by mail. Enrollment can also be completed online. If enrolled online or by telephone, the patient will be given a membership ID number to be used until the permanent discount card arrives in the mail.

*Discount Program
Approved by the FDA to be used together with other drugs to prevent and control nausea and vomiting caused by chemotherapy. It is also used by itself to prevent nausea and vomiting after surgery.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Manufacturer</th>
<th>Participant</th>
<th>Enrollment</th>
<th>Discount Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Epogen</strong></td>
<td>Amgen, Inc.</td>
<td><a href="http://www.esatc.amg.com/medical/edical_reimbursement/nininsured/about.html">http://www.esatc.amg.com/medical/edical_reimbursement/nininsured/about.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 13185</td>
<td>92039</td>
<td>(888)726-6436</td>
<td>(877)727-2867</td>
</tr>
<tr>
<td></td>
<td>La Jolla, CA 92039</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/merckhelps/uninsured/about.html">http://www.merck.com/merckhelps/uninsured/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 13185</td>
<td>92039</td>
<td>(888)726-6436</td>
<td>(877)727-2867</td>
</tr>
<tr>
<td></td>
<td>La Jolla, CA 92039</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.merck.com/medicarebenefits/about.html">http://www.merck.com/medicarebenefits/about.html</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 991</td>
<td>92039</td>
<td>(800)736-0003</td>
<td>(866)694-2545</td>
</tr>
<tr>
<td></td>
<td>Somerville, NJ 08876</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The patient's doctor can request the application by telephone, and it will be faxed to the recipient. The patient and their doctor must complete the application and submit it by fax or mail. The patient's doctor will be notified of the eligibility determination. The medication will be sent within 30 days of eligibility determination.

*Discount Program
Approved by the FDA for the treatment of cancer patients with non-myeloid malignancies who are anemic due to the effect of concomitantly administered chemotherapy. Epogen is indicated to decrease the need for transfusions in patients who will be receiving concomitant chemotherapy for a minimum of 2 months. Epogen is not indicated for the treatment of anemia in cancer patients due to other factors such as iron or folate deficiencies, hemolysis or gastrointestinal bleeding, which should be managed appropriately.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Manufacturer</th>
<th>Participant</th>
<th>Enrollment</th>
<th>Discount Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Erbitux</strong></td>
<td>Bristol-Myers Squibb Company</td>
<td><a href="http://www.merck.com/medicarebenefits/about.html">http://www.merck.com/medicarebenefits/about.html</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 991</td>
<td>08876</td>
<td>(888)735-3725</td>
<td>(866)694-2545</td>
</tr>
<tr>
<td></td>
<td>Somerville, NJ</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The patient's doctor must contact the program to arrange for refills. A new application is required every 12 months.

*Discount Program
Approved by the FDA for the treatment of colorectal cancer that has spread to other areas of the body or has recurred (come back). Cetuximab is sometimes used together with another drug called irinotecan.
Elmidmine
MedImmune, Inc.
8080 little Theater Program
N/A PO Box 222117
Charlotte, NC 28222-
2197
1-800-877-2467; (651)832-
6513.
Elmidrine injection 1ml
The patient must be a US
resident, have no prescription
coverage for the medication
and meet income guidelines that are
not disclosed. There are two
applications for the same
program. One is for patients who
have insurance and the other is
for uninsured patients. The
program also helps with claims
and checking benefits. If the
patient is eligible for Medicare
Part D but does not enroll, they
are not eligible for participation in
this program.

The patient's doctor can
request an application by
phone, and will receive it
by fax. The patient and
their doctor must complete the
application and submit it by fax or
e-mail. The patient's
doctor will be notified of the
eligibility determination.
The eligibility determination
timeline is 2-4 days, and the
medication is shipped
within 2 business days.

Upon eligibility
determination, the
medication is sent to
the patient's doctor.
The doctor must contact the program
to arrange refills. A new
application is
required every 12
months.

Elumeyco
Eli Lilly and Company
Eli Lilly Protect Program
N/A PO Box 222197
Charlotte, NC 28222-
2197
(877)675-6513.
Eli Lilly injection 10ml
The patient must: be a US
resident, have no prescription
coverage for the medication and
meet income guidelines that are
not disclosed. There are two
applications for the same
program. One is for patients who
have insurance and the other is
for uninsured patients. The
program also helps with claims
and checking benefits. If the
patient is eligible for Medicare
Part D but does not enroll, they
are not eligible for participation in
this program.

The patient's doctor can
request an application by
phone, and will receive it
by fax. The patient and
their doctor must complete the
application and submit it by fax or
e-mail. The patient's
doctor will be notified of the
eligibility determination.
The eligibility determination
timeline is 2-4 days, and the
medication is shipped
within 2 business days.

Upon eligibility
determination, the
medication is sent to
the patient's doctor.
The doctor must contact the program
to arrange refills. A new
application is
required every 12
months.

Etrofoten
Eli Lilly and Company
Eli Lilly Protect Program
N/A PO Box 991
Somerville, NJ 08876
(800)736-0003, option 2
(866)694-2545
Bicnu injection 100mg
Ceenu capsules 10 mg
Ceenu capsules 40 mg
Ceenu capsules 100 mg
Etrofoten tablets 500mg
Vumon 500mg/ml
The patient must: be a US
resident, have no prescription
coverage for the medication, and meet undisclosed income
guidelines. If the patient is eligible
for Medicare Part D but has not
enrolled, they may still be eligible
for this program. Patients who are
enrolled in Medicare, Part D who are in the 'Donut Hole' may still be
eligible and should apply, but will
need to submit additional
information stating that they are in the 'Donut Hole.'

The patient's doctor can
request an application by
phone, and the application will be
faxed to the doctor's office. The
patient and their doctor must complete the
application and submit it by fax. The doctor is
notified of the eligibility determination, which is
usually made within 48
hours.

Upon eligibility
determination, the
medication will be sent to
the doctor's office. A refill
request form is included with each
shipment and must
be completed and submitted to receive
a refill. A new
application is required every 6
months.

Fareston
GTX Inc.
GTX Patient Assistance Program
N/A PO Box 8203
Somerville, NJ 08876
(866)325-8231
Fareston tablets 60mg

Applications can be
request by telephone. The application will be
faxed or mailed to the
recipient. The patient and
their doctor must complete the
application and submit it by mail or fax. If the patient is denied
coverage, both the
patient and their doctor are
notified. If approved, the
medication is normally shipped within
7-10 business days.

Upon eligibility
determination, up to a 90-day supply will
be sent to the patient's doctor.
A copy of the
application with new
signatures and a
new prescription is
required for each
refill. A new
application with documentation is
required every 12
months.

GTX Patient
Assistance Program

FDA approved for the management of Refractory Testicular Tumors. Approved for combination
therapy with other approved
therapeutic agents in patients with refractory testicular tumors who have already received
appropriate surgical,
thecapeutical, and
radiotherapeutic therapy. Approved for combination
therapy with other approved
therapeutic agents as first line treatment in patients with small cell
cancer.
Once eligibility has been determined, a 90-day supply will be sent to the doctor. The patient or their doctor must contact the program for refills. A new application with documentation is required every 12 months.

The patient must: be a US citizen; have no insurance, and meet undisclosed income guidelines. If the patient has insurance, but it does not cover these drugs, they must obtain proof of non-coverage and then they will be considered on a case-by-case basis.

The patient must be a US citizen or have a valid visa; not have prescription insurance; be ineligible for any government programs; and have an income at or below 250% of the Federal Poverty Level. Patients who are eligible for Medicare Part D but did not enroll, or is enrolled in Medicare Part D and is in the ‘Donut Hole’ then they are not eligible for the program. If the patient calls for the prescreening and qualifies for the program, their doctor will have to then contact the program.

The patient must complete the application and submit it by fax or regular mail. The application is a two-part process. The first application contains basic information and does not require signatures. The patient and their doctor must complete the second application, which requires signatures and the patient's proof of insurance. The completed application must be submitted by fax. Both the patient and their doctor are notified of the eligibility determination. The determination is made within 5-7 business days.

**Faslodex Fulvestrant AstraZeneca**

Approved by the FDA to treat certain types of breast cancer in postmenopausal women. It is not approved for use in breast cancer in premenopausal women. It is also not approved for use in breast cancer that is refractory to estrogen receptor positive or has spread to other areas of the body, after treatment with other aromatase inhibitors.

Arimidex tablets 1mg  Faslodex injection 2.5 ml Trazodone depot 3.6 mg (monthly) Zoladex depot 10.8 mg (every 3 months)
Lilly Oncology: Novartis Oncology

Upon eligibility determination, the medication will be sent to either the doctor's office. The doctor must fill out a replacement form to obtain refills. A new application is required every 12 months. The requested amount is sent to the hospital.

Gemzar
Gemcitabine
Hydrocloride

Approved by the FDA to treat cancer of the breast, pancreas, ovary, and lung.

Gleevec
Imatinib Mesylate

Approved by the FDA to treat leukemia (Philadelphia chromosome positive chronic myelogenous leukemia, hypereosinophilic syndrome or chronic eosinophilic leukemia, relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia), gastrointestinal stromal tumor, dermatofibrosarcoma protuberans, myelodysplastic/myeloproliferative disorders, systolic mastocytosis.

Gliadel Wafer
Carmustine with Polylactic acid Implant

Approved by the FDA to treat glioblastoma multiforme who qualify for surgery.

Herceptin
Trastuzumab

Approved by the FDA to treat breast cancer that is HER2-positive and has metastasized (spread to other areas of the body) after treatment with other anticancer drugs. Trastuzumab is also approved to be used with other drugs to treat HER2-positive breast cancer after surgery.

Glenaral
Glenaral Hydrochloride

Approved by the FDA to treat cancer of the breast, pancreas, ovary, and lung.
Hexalen capsules 50 mg
The patient must not have any insurance and must meet undisclosed income guidelines.

The patient’s doctor must call for a prescreening, and then the application will be sent to the doctor. The patient and their doctor must complete the application and submit by fax or email. Both the patient and their doctor will be notified of the eligibility determination and the medication will be shipped within 2 business days.

The medication is sent to the patient’s doctor. The doctor must arrange for refills. A new application is required every 12 months.

Hycamtin Topotecan Hydrochloride

The patient’s doctor must call for a prescreening, and then the application will be sent to the doctor. The patient and their doctor must complete the application and submit by fax or email. Both the patient and their doctor will be notified of the eligibility determination and the medication will be shipped within 2 business days.

The medication is sent to the patient’s doctor. The doctor must arrange for refills. A new application is required every 12 months.
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program.

The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

The application may be requested by telephone, and will be faxed or mailed to the person requesting it. The patient and their doctor must complete the application and submit by fax or mail. Both the patient and their doctor are notified of the eligibility determination, which is usually made within 24-48 hours. Once the determination has been made, the medication is shipped the next day.

Upon eligibility determination, up to a 30-day supply will be sent to the patient's home or their doctor. The company will contact the patient when they require a new application.

The program is based on undisclosed guidelines. The program is not taking any new patients who have not been prescribed the medication before September 15, 2005. The application may be requested by telephone or website. The patient and their doctor must complete the application and submit by fax or mail. Both the patient and their doctor are notified of the eligibility determination, and the medication is shipped the next day.

Upon eligibility determination, up to a 30-day supply is sent to the patient's home or their doctor. The patient must contact the program to arrange for refills, and a new application with documentation is required once every 12 months.

Approved by the FDA for the treatment of patients 18 years of age or older with hairy cell leukemia.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Description</th>
<th>Program Name</th>
<th>Contact Information</th>
<th>Eligibility Requirements</th>
</tr>
</thead>
</table>
| Kepivance       | Palifermin is approved by the FDA to help prevent and treat severe oral mucositis in patients with leukemia or lymphoma who receive high doses of chemotherapy and radiation therapy. | Safety Net Foundation            | [Link](http://wwwext.amgen.com/medpro/medical_reimbursement/reimbursement_connection.htm) |PO Box 13185, La Jolla, CA 92039  
(888)20-6438  
(877)727-2867  
The eligibility requirements are not disclosed. This is a replacement program, so the Form C can only be sent in after the patient has used the medication. The patient's doctor must sponsor the patient for enrollment in the program. If the patient is eligible for Medicare Part D, they are not eligible for this program. The patient's doctor can request the application by telephone, and it will be sent to them by fax. The patient and their doctor must complete the application and submit it by fax or mail. The patient's doctor will be notified of the eligibility determination. The medication will be sent within 30 days of eligibility determination. Up to a 30-day supply is sent to the patient's doctor. A refill form is included with each shipment, and must be completed and returned to receive the next shipment. A new application with documentation is required every 12 months. |
| Aranesp         | Epogen and Neupogen are approved by the FDA for use in the treatment of anemia in patients with chronic kidney disease, cancer, and other conditions. | Amgen, Inc.                      | [Link](http://wwwext.amgen.com/medpro/medical_reimbursement/reimbursement_connection.htm) |PO Box 52028, Phoenix, AZ 85072-9937  
(877)254-1039  
(888)782-6157  
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program. The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months. |
| Aranesp         | Aranesp is approved by the FDA for the treatment of anemia in patients with chronic kidney disease, cancer, and other conditions. | Amgen, Inc.                      | [Link](http://wwwext.amgen.com/medpro/medical_reimbursement/reimbursement_connection.htm) |PO Box 52028, Phoenix, AZ 85072-9937  
(877)254-1039  
(888)782-6157  
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program. The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months. |
| Aranesp         | Aranesp is approved by the FDA for the treatment of anemia in patients with chronic kidney disease, cancer, and other conditions. | Amgen, Inc.                      | [Link](http://wwwext.amgen.com/medpro/medical_reimbursement/reimbursement_connection.htm) |PO Box 52028, Phoenix, AZ 85072-9937  
(877)254-1039  
(888)782-6157  
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program. The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months. |
| Leucovorin      | Leucovorin is approved by the FDA for use in combination with fluorouracil to prolong survival in the palliative treatment of patients with advanced colorectal cancer. | TEVA Pharmaceuticals            | [Link](http://wwwext.amgen.com/medpro/medical_reimbursement/reimbursement_connection.htm) |PO Box 52028, Phoenix, AZ 85072-9937  
(877)254-1039  
(888)782-6157  
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program. The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months. |
| Leucovorin      | Leucovorin is approved by the FDA for use in combination with fluorouracil to prolong survival in the palliative treatment of patients with advanced colorectal cancer. | TEVA Pharmaceuticals            | [Link](http://wwwext.amgen.com/medpro/medical_reimbursement/reimbursement_connection.htm) |PO Box 52028, Phoenix, AZ 85072-9937  
(877)254-1039  
(888)782-6157  
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program. The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once the eligibility determination has been made, the medication will be sent to the doctor's office. It is the doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months. |
Leukeran Chlorambucil GlaxoSmithKline Commitment to Access http://www.commitmenttoaccess.com
PO Box 29038 Phoenix, AZ 85038-9038 (866)265-4491 N/A
Amoxan injection Bexar injection 14mg/ml Hydramid injection 4mg/ml Leukeran tablets 2mg Myleran tablets 2mg
The patient must be a US resident; have no prescription coverage for the medication; and have an income at or below 350% of the Federal Poverty Level. GlaxoSmithKline requests that an “Advocate” be the contact person for the patient throughout the entire process. The advocate can be any healthcare worker involved in the patient’s care (i.e., doctor, nurse, social worker, or someone in the healthcare office or facility). The application needs a total of 3 signatures: doctor, patient and advocate. If the patient chooses not to enroll in Medicare Part D, then they are eligible to be on this program. Each application must have a unique patient ID number.

The application can be requested by telephone, or can be started online. If requested by telephone, the application will be faxed or mailed to the patient advocate or patient. The patient and their doctor must complete the application. Once completed, the patient advocate must call for a phone screening, and then they must submit the application by mail. Notification of eligibility determination is sent to whomever started the application process. Upon eligibility determination, a 30-day supply will be sent to the patient's doctor. It is the doctor’s responsibility to contact the program to arrange for refills. A new application is required every 12 months.

PO Box 221289 Charlotte, NC 28222-1289 (800)321-4669 (800)513-1824
Campath Injection 25ml Fludara injection 50 mg Leukine liquid 500 mcg Leukin lyophilized 250 mcg
The patient must: be a US citizen, have no insurance, and meet undisclosed income guidelines. If the patient has insurance, but it does not cover these drugs, they must obtain proof of non-coverage and then they will be considered on a case-by-case basis.

The patient’s doctor must submit a letter on letterhead stating their patient’s need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative. Upon eligibility determination, the medication will be sent to the patient’s doctor. The patient’s doctor must contact the program to arrange for refills. A new application will be required every 6 months.

Leulasyn Cladribine Bedford Laboratories Bedford Laboratories
http://www.bedfordlabs.com/index
300 Northfield Rd. Bedford, OH 44146 (800)562-4797, option 2 (440)232-6264
Biomyxin injection 5ml Daunorubicin injection 20mg/ml Daunomycin injection 200 mg/ml Daucarbine injection 10mg Measna injection 1g/10ml Methotrexate injection 1 gram Mitomycin injection 5mg Vinorelbine injection 10mg/ml Capclacin injection 50mg/ml Docosbound injection mg
Decisions are made on a case-by-case basis.

The patient's doctor must submit a letter on letterhead stating their patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative. N/A N/A
Approved by the FDA for the treatment of chronic lymphatic (lymphocytic) leukemia, malignant lymphomas including lymphosarcoma, giant follicular lymphoma, and Hodgkin’s disease. It is not curative in any of these disorders but may produce clinically useful palliation.

Leulieu Stanimastatin Berlex Laboratories
PM Mkt V41329 Charlotte, NC 28222-1289
N/A N/A
Approved by the FDA for use following induction chemotherapy in older adult patients with acute myelogenous leukemia (AML) to shorten time to neutrophil recovery and to reduce the incidence of severe and life-threatening infections and infections resulting in death.

Leulastin Cisplatin Bedford Laboratories
http://www.bedfordlabs.com/index
200 Northfield Rd. Bedford, OH 44146 (800)562-4797, option 2 (440)232-6264
Bleomycin injection 5ml Daunomycin injection 20mg/ml Daunorubicin injection 200mg/ml Cladribine injection 10mg Leukeran tablets 2mg Mitomycin injection 5mg Vinorelbine injection 10mg/ml Cisplatin injection 50mg/ml Doxorubicin injection 50mg/ml
Decisions are made on a case-by-case basis.

The doctor must submit a letter on letterhead stating their patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative. N/A N/A
Approved by the FDA for the treatment of active Hairy Cell Leukemia as defined by clinically significant anemia, neutropenia, thrombocytopenia or disease-related symptoms.
The patient must: be a US resident, have no prescription coverage for the medication, and meet undisclosed income guidelines. If the patient is eligible for Medicare Part D but has not enrolled, they may still be eligible for this program. Patients who are enrolled in Medicare, Part D who are in the 'Donut Hole' may still be eligible and should apply, but will need to submit additional information stating that they are in the 'Donut Hole.' The doctor can request an application by telephone, and the application will be faxed to the doctor's office. The patient and their doctor must complete the application and submit it by fax. The doctor is notified of the eligibility determination, which is usually made within 48 hours. Once eligibility is determined, the medication will be sent to the doctor's office. A refill request form is included with each shipment and must be completed and submitted to receive a refill. A new application is required every 6 months.
<table>
<thead>
<tr>
<th>Methotrexate molecular weight: 174.14</th>
<th>Methotrexate, 1 g, vial</th>
<th><a href="http://www.bedfordlabs.com/index">http://www.bedfordlabs.com/index</a></th>
<th>300 Northfield Rd, Bedford, OH 44146</th>
<th>(800) 562-4797, option 2</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

### Indications

Decisions are made on a case-by-case basis. The patient’s doctor must submit a letter on letterhead stating their patient’s need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative.

N/A N/A Approved by the FDA for the treatment of gestational choriocarcinoma, chorioadenoma destruens and hydatidiform mole. In acute lymphocytic leukemia, methotrexate is indicated in the prophylaxis of meningeal leukemia and is used in maintenance therapy in combination with other chemotherapeutic agents. Methotrexate is also indicated in the treatment of meningeal leukemia. Methotrexate is used alone or in combination with other anticancer agents in the treatment of breast cancer, epidermoid cancers of the head and neck, advanced mycosis fungoides, and lung cancer, particularly squamous cell and small cell types. Methotrexate is also used in combination with other chemotherapeutic agents in the treatment of advanced stage non-Hodgkin’s lymphomas. Methotrexate in high doses followed by leucovorin rescue in combination with other chemotherapeutic agents is effective in prolonging relapse-free survival in patients with non-metastatic osteosarcoma who have undergone surgical resection or amputation for the primary tumor. Psoriasis: Methotrexate is indicated in the symptomatic control of severe, recalcitrant, disabling psoriasis that is not adequately responsive to other forms of therapy, but only when the diagnosis has been established, as by biopsy and/or after dermatologic consultation. It is important to ensure that a psoriasis “flare” is not due to an undiagnosed concomitant disease affecting immune responses. Rheumatoid Arthritis: Methotrexate is indicated in the symptoms of disease exacerbation in patients who are already receiving methotrexate in combination with other therapy, including non-steroidal anti-inflammatory drugs. Methotrexate is also indicated in the treatment of psoriatic arthritis.

### Usage

- **Cisplatin injection 50 mg/ml**
- **Doxorubicin injection 4 mg**
- **Methotrexate injection 1 gram**
- **Mitomycin injection 5 mg**
- **Vinorelbine injection 10 mg/ml**
- **Cisplatin injection 50 mg/ml**
- **Doxorubicin injection 4 mg**
- **Methotrexate injection 1 gram**
- **Mitomycin injection 5 mg**
- **Vinorelbine injection 10 mg/ml**
- **Cisplatin injection 50 mg/ml**
- **Doxorubicin injection 4 mg**
- **Methotrexate injection 1 gram**
- **Mitomycin injection 5 mg**
- **Vinorelbine injection 10 mg/ml**
management of selected adults with severe, active, classical or definite rheumatoid arthritis (ARA criteria) who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose NSAIDs and usually a trial of at least one or more disease-modifying antirheumatic drugs. Aspirin, nonsteroidal anti-inflammatory agents, and/or low dose steroids may be continued, although the possibility of increased toxicity with concomitant use of NSAIDs including salicylates has not been fully explored. (See PRECAUTIONS, Drug Interactions.) Steroids may be reduced gradually in patients who respond to methotrexate. Combined use of methotrexate with gold, penicillamine, hydroxychloroquine, sulfasalazine, or cytotoxic agents, has not been studied and may increase the incidence of adverse effects. Rest and physiotherapy as indicated should be continued.


Mitozytrex Injection 5mg Daunorubicin Injection 20mg/4ml Doxorubicin Injection 20mg/4ml

Decisions are made on a case-by-case basis. The patient’s doctor must submit a letter on the patient’s need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative. The patient or their doctor must call for prescreening. The application will be sent to the patient or their doctor and their doctor must complete the application and submit by fax or mail. The eligibility determination will be sent to whomever initiated the application process.

NDA

MUSTARGEN,
Treatment of metastatic carcinoma resulting in effusion.

**Myleran**
Bisulfan oral
GlaxoSmithKline
Commitment to Access
http://www.commitmenttoaccess.com/
PO Box 29038
Phoenix, AZ 85038-9038
(866)365-6461
N/A
Anranon injection
Boxcar injection 14mg/ml
Myleran injection 4mg/ml
Leukeran tablets 2mg
Myleran tablets 2mg
The patient must: be a US resident; have no prescription coverage for the medication; and have an income at or below 350% of the Federal Poverty Level. GlaxoSmithKline requests that an “Advocate” be the contact person for the patient throughout the entire process. The advocate can be any healthcare worker involved in the patient’s care (i.e., doctor, nurse, social worker, or someone in the healthcare office or facility). The application needs a total of 3 signatures: doctor, patient and advocate. If the patient choses not to enroll in Medicare Part D, then they are eligible to be on this program. Each application must have a unique patient ID number. The application can be requested by telephone, or can be started online. If requested by telephone, the application will be faxed or mailed to the patient advocate or patient. The patient and their doctor must complete the application. Once completed, the patient advocate must call for a phone screening, and then they must submit the application by mail. Notification of eligibility determination is send to whoever started the application process. Upon eligibility determination, a 30-day supply will be sent to the patient’s doctor. It is the doctor’s responsibility to contact the program to arrange for refills. A new application is required every 12 months.

**Myltarg**
Omtuzamab Ozogamicin
Wyeth Pharmaceuticals
Wyeth Oncology Reimbursement Program
http://www.wyeth/contact? hinder.html#home/requests/ forwards/requests/Patient _assist.html
Lash Group
PO Box 1285
San Bruno, CA 94066
(866) 836-0819
Myltarg Neumega
The patient must: be under the treatment of a US doctor, have no prescription coverage for the medication and have an income at or below 325% of the Federal Poverty Level. The program also provides drug replacement if the insurance is denied and it is for an FDA-approved diagnosis. The doctor may request the application by phone, and it will be faxed to the doctor. The patient and their doctor must complete the application and submit by mail. Both the patient and their doctor will be notified in writing of the eligibility determination. The medication will be shipped within 10 business days. Upon eligibility determination, up to a 90-day supply will be sent to the patient’s doctor. The doctor must contact the program to request refills. A new application with documentation is required every 12 months.

**Mylotarg**
Gemtuzumab Ozogamicin
Wyeth Pharmaceuticals
Wyeth Oncology Reimbursement Program
http://www.wyeth.com/contact? hinder.html#home/requests/ forwards/requests/Patient _assist.html
Lash Group
PO Box 1285
San Bruno, CA 94066
(866) 836-0819
Mylotarg Neumega
The patient must: be under the treatment of a US doctor, have no prescription coverage for the medication and have an income at or below 325% of the Federal Poverty Level. The program also provides drug replacement if the insurance is denied and it is for an FDA-approved diagnosis. The doctor may request the application by phone, and it will be faxed to the doctor. The patient and their doctor must complete the application and submit by mail. Both the patient and their doctor will be notified in writing of the eligibility determination. The medication will be shipped within 10 business days. Upon eligibility determination, up to a 90-day supply will be sent to the patient’s doctor. The doctor must contact the program to request refills. A new application with documentation is required every 12 months.
SafetyNet

Upon eligibility determination, up to a 30-day supply is sent to the patient's doctor. A refill form is included with each shipment, and must be completed and returned to Neulasta 6mg. The patient's doctor can request the application by telephone, and it will be sent to them by fax. The patient and their doctor must complete the application and submit it by fax or mail. The patient's doctor will be notified of the eligibility determination. The medication will be sent within 30 days of eligibility determination.

Upon eligibility determination, up to a 30-day supply is sent to the patient's doctor. A refill form is included with each shipment, and must be completed and returned to receive the next shipment. A new application with documentation is required every 12 months.

Approved by the FDA to decrease the incidence of infection, as manifested by neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of severe neutropenia.

Wyeth Oncology

Reimbursement Program


The patient must: be under the treatment of a US doctor, have no prescription coverage for the medication and have an income at or below 325% of the Federal Poverty Level. The program also provides drug replacement if the insurance is denied and it is for an FDA-approved diagnosis. The patient may request the application by phone, and it will be faxed to the doctor. The patient and their doctor must complete the application and submit it by fax or mail. Both the patient and their doctor will be notified in writing of the eligibility determination. The medication will be shipped within 10 business days.

Upon eligibility determination, up to a 30-day supply is sent to the patient's doctor. The doctor must contact the program to request refill(s). A new application with documentation is required every 12 months.

Approved by the FDA for the prevention of severe thrombocytopenia and the reduction of the need for platelet transfusions following myelosuppressive chemotherapy in adult patients with nonmyeloid malignancies who are at high risk of severe thrombocytopenia.

Wyeth Oncology

Reimbursement Program


The patient must: be under the treatment of a US doctor, have no prescription coverage for the medication and have an income at or below 325% of the Federal Poverty Level. The program also provides drug replacement if the insurance is denied and it is for an FDA-approved diagnosis. The patient may request the application by phone, and it will be faxed to the doctor. The patient and their doctor must complete the application and submit it by fax or mail. Both the patient and their doctor will be notified in writing of the eligibility determination. The medication will be shipped within 10 business days.

Upon eligibility determination, up to a 30-day supply is sent to the patient's doctor. The doctor must contact the program to request refill(s). A new application with documentation is required every 12 months.

Approved by the FDA to decrease the incidence of infection, as manifested by neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.
Approved by the FDA as a single-agent or in combination with other approved drug(s) for the first-line treatment of ambulatory patients with unresectable, advanced nonsmall cell lung cancer (NSCLC). The patient's doctor must submit a letter on letterhead stating their patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative.

Decisions are made on a case-by-case basis.

The patient's doctor must submit a letter on letterhead stating their patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative.

The patient must complete the application and submit the application. The medication will be sent to the patient's home. The program will contact the patient to arrange for refills.

The patient must be a US resident, have no prescription coverage and meet undisclosed income guidelines.

The application may be requested by phone and will be sent to the patient's doctor. The patient and their doctor must complete the application and submit by fax or mail. Eligibility determination will be made within 24-48 hours and the medication will be shipped within 2 business days.

The patient must have an income at or below 250% of the Federal Poverty Level. This program is for generic medications only. The locations will be available at an administrative fee of $20 or $30 for each 90-day supply.

Applications can be requested by phone or downloaded from the website, and will be sent out by fax or mail. The patient and their doctor must complete the application and submit by mail. The patient will be notified of the eligibility determination.

Upon eligibility determination, up to a 30-day supply will be sent to the patient's doctor. The program will contact the doctor to arrange refills. A new application is required every 12 months.

Upon eligibility determination, up to a 90-day supply will be sent to the patient's doctor. The program will contact the patient to arrange refills. A new application is required every 12 months.

The medication will be sent to the patient's home. The program will contact the patient to arrange for refills.

The patient and their doctor must complete and submit by fax or mail. Eligibility determination will be made within 24-48 hours and the medication will be shipped within 2 business days.

Applications can be requested by phone or downloaded from the website, and will be sent out by fax or mail. The patient and their doctor must complete the application and submit by mail. The patient will be notified of the eligibility determination.

Upon eligibility determination, up to a 30-day supply will be sent to the patient's doctor. The program will contact the doctor to arrange refills. A new application is required every 12 months.

The patient must complete the application and submit by fax or mail. Eligibility determination will be made within 24-48 hours and the medication will be shipped within 2 business days.

Applications can be requested by phone or downloaded from the website, and will be sent out by fax or mail. The patient and their doctor must complete the application and submit by mail. The patient will be notified of the eligibility determination.

Upon eligibility determination, up to a 90-day supply will be sent to the patient's doctor. The program will contact the patient to arrange refills. A new application is required every 12 months.

The patient must have an income at or below 250% of the Federal Poverty Level. This program is for generic medications only. The locations will be available at an administrative fee of $20 or $30 for each 90-day supply.

Applications can be requested by phone or downloaded from the website, and will be sent out by fax or mail. The patient and their doctor must complete the application and submit by mail. The patient will be notified of the eligibility determination.

Upon eligibility determination, up to a 30-day supply will be sent to the patient's doctor. The program will contact the patient to arrange refills. A new application is required every 12 months.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Company</th>
<th>Assistance Program</th>
<th>Program Website</th>
<th>Patient Assistance Number</th>
<th>Drug Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncaspar</td>
<td>Enzon</td>
<td>Enzon Patient Assistance Program</td>
<td><a href="http://www.enzon.com">http://www.enzon.com</a></td>
<td>(888)276-2217, option 5</td>
<td>Approved by the FDA to be used together with other drugs to treat acute lymphoblastic leukemia (ALL).</td>
</tr>
<tr>
<td>Pegaspargase</td>
<td>Enzon</td>
<td>Enzon Patient Assistance Program</td>
<td><a href="http://www.enzon.com">http://www.enzon.com</a></td>
<td>(888)276-2217, option 5</td>
<td>Approved by the FDA for the treatment of patients with persistent or recurring cutaneous T-cell lymphoma whose malignant cells express the CD25 component of the IL-2 receptor (See PRECAUTIONS, Laboratory Tests, for CD25 expression testing).</td>
</tr>
<tr>
<td>Ontak</td>
<td>Denkauhn, Denkauhn</td>
<td>Eisai Oncology Reimbursement Assistance</td>
<td>N/A</td>
<td>(877)654-4263, (877)654-5700</td>
<td>Approved by the FDA for the treatment of patients with persistent or recurrent cutaneous T-cell lymphoma whose malignant cells express the CD25 component of the IL-2 receptor (See PRECAUTIONS, Laboratory Tests, for CD25 expression testing).</td>
</tr>
<tr>
<td>Panretin</td>
<td>Allretin</td>
<td>Eisai Oncology Reimbursement Assistance</td>
<td>N/A</td>
<td>(877)654-4263, (877)654-5700</td>
<td>Approved by FDA for topical treatment of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma. Panretin gel is not indicated when systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement). There is no experience to date using Panretin gel with systemic anti-KS treatment.</td>
</tr>
</tbody>
</table>
Cisplatin

Bedford Laboratories

http://www.bedfordlabs.com/index

300 Northfield Rd. Bedford, OH 44146

(800)562-4797, option 2

(440)232-6264

Bleomycin injection 5ml
Daunorubicin injection 20mg/4ml
Dacarbazine Injection 200 mg
Cladribine injection 10mg
Mitomycin injection 1mg/10ml
Methotrexate injection 1 gram
Vincristine injection 1mg
Cisplatin injection 50mg/ml
Doxorubicin injection mg

Decisions are made on a case-by-case basis.

The patient's doctor must submit a letter on letterhead stating their patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative.

Cisplatin is approved by the Food and Drug Administration (FDA) to be used by itself to treat the following conditions:
- Bladder cancer that cannot be treated with surgery or radiotherapy;
- Ovarian cancer that has metastasized (spread to other parts of the body) and has not gotten better with other drugs.

Cisplatin is also approved to be used together with other drugs to treat the following conditions:
- Advanced ovarian cancer in patients who have already had surgery;
- Metastatic ovarian cancer in patients who have already had surgery or radiotherapy;
- Testicular cancer in patients who have already had surgery or radiotherapy;
- Locally advanced squamous cell carcinoma of the head and neck (SCCHN) that cannot be treated with surgery;
- Late-stage cervical cancer that cannot be treated with surgery or radiotherapy;
- Malignant mesothelioma that cannot be treated with surgery; and
- Locally advanced, advanced, or metastatic non-small cell lung cancer (NSCLC) that cannot be treated with surgery.

N/A

N/A

Proleukin

Novartis Pharmaceuticals

Proleukin Reimbursement Program

PO Box 221644
Chantilly, VA 20153-1644

(866)385-4729

(703)968-2900

Femara tablets 2.5mg
Gleevec capsules 100 mg
Gleevec tablets 100mg
Proleukin
Zometa injection 2 mg
Zometa injection 4 mg
Zometa injection 8 mg
Zometa injection 16 mg

The patient must have no prescription coverage for the medication and must meet undisclosed income guidelines. The patient must be a US resident and must be enrolled in this program prior to starting therapy.

The patient's doctor must call for a prescreening, and then the application and submit by fax or email. The patient's doctor will be notified of the eligibility determination.

Upon eligibility determination, the medication will be sent to the patient's doctor. A new application is required every 12 months.

N/A

N/A

Proleukin is approved by the FDA for the treatment of adults with metastatic renal cell carcinoma (metastatic RCC), and for the treatment of adults with metastatic melanoma.
Once the eligibility determination has been made, the medication will be sent to the patient's home or office. It is the patient's doctor's responsibility to contact the program to request refills when they are needed. A new application is required every 6 months.

Eligibility:
- The patient must be a U.S. resident.
- No prescription coverage for the medication.
- An income at or below 200% of the Federal Poverty Level.
- Projected annual income guidelines.
- Patients who are eligible for Medicaid Part D but have not enrolled and could still be eligible for this program should apply.
- The patient's doctor can request an application by calling the program to arrange for refills. A new application is required every six months.

The eligibility guidelines for this program are not disclosed. If the patient is eligible for Part D but does not enroll then s/he still may be eligible for this program.

The patient's doctor can call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

Once the eligibility determination has been made, the medication will be sent to the patient's doctor. The doctor's office must contact the program to arrange for refills. A new application is required every six months.

Approved by the FDA to treat anemia caused by a certain type of myelodysplastic syndrome (MDS). It is only available as a part of a special program called RevAssist. Lenalidomide is also approved to treat multiple myeloma.

Lenalidomide is also approved to treat multiple myeloma.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Organization</th>
<th>Bedford Laboratories</th>
<th>Bedford Laboratories</th>
<th><a href="http://www.bedfordlabs.com/index">http://www.bedfordlabs.com/index</a></th>
<th>PO Box 2975</th>
<th>Phoenix, AZ 85062-8963</th>
<th>(877) 74-5675</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camptosar® (irinotecan HCl injection), Elunera® (apalutamide), hydrochloride, Zometa® (zoledronic acid injection), Emcyt® (estramustine phosphate sodium capsules), Idamycin® (idarubicin HCl), Sutent® (sunitinib malate), Zinecard® (dexrazoxane for injection)</td>
<td>Pfizer, Inc.</td>
<td>N/A</td>
<td>First Resource Program for Oral Medications</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Rubex</strong> Doxorubicin</td>
<td>Bedford Laboratories</td>
<td>Bedford Laboratories</td>
<td>Bedford Laboratories</td>
<td><a href="http://www.bedfordlabs.com/index">http://www.bedfordlabs.com/index</a></td>
<td>300 Northfield Rd, Bedford, OH 44146</td>
<td>(800) 562-4797, option 2</td>
<td>(440) 232-6264</td>
</tr>
<tr>
<td><strong>Sprycel</strong> Masitinib</td>
<td>Bristol-Myers Squibb Company</td>
<td>Bristol-Myers Squibb Patient Assistance Program for Sprycel</td>
<td><a href="http://www.bmspaf.org">www.bmspaf.org</a></td>
<td>PO Box 591 Somerville, NJ 08876</td>
<td>(800) 736-0003</td>
<td>(866) 694-2549</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Sutent</strong></td>
<td>Sunthine-Makare</td>
<td>Pfizer, Inc.</td>
<td>First Resource Program for Oral Medications</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

- **Rubex (Doxorubicin)**
  - Decisions are made on a case-by-case basis.
  - The patient's doctor must submit a letter on letterhead stating the patient's need, lack of prescription coverage, and attach a prescription. Alternatively, they may provide their information to their drug representative.

- **Sprycel (Masitinib)**
  - The patient must have no prescription coverage for any medications and must meet undisclosed income guidelines.
  - The application can be downloaded from the website or requested by telephone. If requested by telephone, the application will be faxed to the recipient. The patient and their doctor must complete the application and submit it by fax or email. Both the patient and the doctor are notified of the eligibility determination.

- **Sutent (Sunitinib Malate)**
  - The patient must be a US resident; have no prescription coverage for the medication; and meet income guidelines. Patients who are eligible for Medicare Part D but have not enrolled may still be eligible for this program.
  - The doctor, patient, social worker or patient advocate must call for a prescreening. The application is sent to either the doctor or patient depending on the medication requested. The patient and their doctor must complete the application and the patient must submit it by fax or email. Both the patient and doctor are notified in writing of the eligibility determination. The determinations are usually made within 48 hours. If the patient is deemed eligible, the medication will be shipped out within 5-7 business days.

- **Sprycel (Masitinib)**
  - Upon eligibility determination, up to a 90-day supply will be sent to the patient's home. The program will contact the patient's doctor to arrange for refills. A new application with documentation must be submitted every 12 months.

- **Sutent (Sunitinib Malate)**
  - Upon eligibility determination, up to a 90-day supply will be sent to the patient's home. The program will contact the patient's doctor to arrange for refills. A new application with documentation must be submitted every 12 months.

- **Rubex (Doxorubicin)**
  - Approved by the FDA for the treatment of metastatic carcinoma of the ovary in patients with disease that is refractory to both paclitaxel- and platinum-based chemotherapy regimens. Refractory disease is defined as disease that has progressed while on treatment, or within 6 months of completing treatment. The treatment of AIDS-related Kaposis sarcoma in patients with disease that has progressed on prior combination chemotherapy or in patients who are intolerant to such therapy.

- **Sprycel (Masitinib)**
  - Approved by the FDA to treat chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL) in patients who were not able to use other drugs.

- **Sutent (Sunitinib Malate)**
  - Approved by the FDA to treat a type of stomach cancer called gastrointestinal stromal tumor (GIST). It is used in patients whose condition has become worse while taking another drug called imatinib mesylate or who are not able to take imatinib mesylate.

- **Rubex (Doxorubicin)**
  - Approved by the FDA for the treatment of metastatic carcinoma of the ovary in patients with disease that is refractory to both paclitaxel- and platinum-based chemotherapy regimens. Refractory disease is defined as disease that has progressed while on treatment, or within 6 months of completing treatment. The treatment of AIDS-related Kaposis sarcoma in patients with disease that has progressed on prior combination chemotherapy or in patients who are intolerant to such therapy.
Approved by the FDA to treat non-small cell lung cancer that has metastasized (spread) and that has not gotten better with chemotherapy. Also approved to be used together with a drug called gemcitabine to treat pancreatic cancer that cannot be removed by surgery or has metastasized (spread).

This is a drug replacement program. The medication will be sent to the patient's doctor.

Requested by phone or fax, the application will be faxed or mailed to the recipient. The patient and their doctor must complete the application and submit by fax or mail. The patient's doctor will be notified of the eligibility determination in writing. The determination is usually made within 48 hours. Medication will be shipped the next day.

Upon eligibility determination, the medication is sent to the patient's doctor. The company will contact the patient's doctor to arrange for refill.

Approved by the FDA to treat non-small cell lung cancer that has metastasized (spread) and that has not gotten better with chemotherapy. Also approved to be used together with a drug called gemcitabine to treat pancreatic cancer that cannot be removed by surgery or has metastasized (spread).

Approved by the FDA to treat skin problems caused by cutaneous T-cell lymphoma that have not gotten better with other treatment.

Approved by the FDA to treat breast cancer, gastric cancer, and prostate cancer. Docetaxel is also approved to be used with other drugs to treat advanced squamous cell carcinoma of the head and neck (SCCHN) that cannot be removed by surgery.

Approved by the FDA to treat two different types of brain tumor -- anaplastic astrocytoma and glioblastoma multiforme (GBM).
Upon eligibility determination, the medication is sent to the patient's doctor. The doctor's office program to arrange for refills. A new application will be requested by the patient or their doctor. The patient must have no prescription coverage for the medication and meet undisclosed income guidelines. Patients who are eligible for Medicaid Part D but have not enrolled and could still be eligible for this program should apply. The application can be downloaded from the website or requested by telephone. If requested by telephone, the application will be faxed to the recipient. The patient and their doctor must complete the application and submit it by fax or email. Both the patient and their doctor are notified of the eligibility determination, which is usually made within 48 hours. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must apply to Medicaid, have no prescription insurance and have an income at a level below 200% of the Federal Poverty Level. The patient must have been rejected for Medicaid Part D. The patient and their doctor must complete the application and submit it by fax. The patient and their doctor can request an application by telephone, and will receive the application by fax. The patient and their doctor must complete the application and submit it by fax. The patient and their doctor can request an application by telephone, and will receive the application by fax. The patient and their doctor must complete the application and submit it by fax. The patient's doctor can request an application by telephone, and will receive the application by fax. The patient and their doctor must complete the application and submit it by fax. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level. The patient must have applied to Medicaid, been denied, have no prescription insurance and have an income at or below the Federal Poverty Level.
Velcade
Bortezomib
Millenium Pharmaceuticals, Inc.

Velcade Patient Assistance for Velcade N/A PO Box 22087 Charlotte, NC 28202-1087 (866)891-9843 Velcade injection

The patient must be a US resident, have no insurance and meet undisclosed income guidelines. The patient must be taking the medication for a FDA-approved diagnosis and have failed at least two prior therapies. This program will also help with research to find other sources of payment if the co-pay of Medicare is too high.

The patient’s doctor can request an application by telephone. The application will be sent to the patient’s doctor and should be complete by the patient and the doctor. The application should be submitted by fax or email and the eligibility determination will be sent to the patient’s doctor. The eligibility determination is usually made within 48 hours and the medication is shipped within 48 hours of the eligibility determination.

Upon eligibility determination, up to a 30-day supply will be sent to the patient’s doctor. The program will contact the doctor to arrange for refills. A new application is required every 12 months.

Millenium Patient Assistance for Velcade
Approved by the FDA to treat multiple myeloma that has gotten worse during treatment with other drugs. Bortezomib is also approved to treat mantle cell lymphoma in patients who have already received at least one other type of treatment.

Vesanoid
ATRA, Tretinoin
Roche Pharmaceuticals

Roche Oriconze Patient Assistance Program N/A PO Box 18647 Louisville, KY 40261 (888)587-9438 (866)496-8702 Roferon-a injection 3 miu Roferon-a injection 6 miu Roferon-a injection 9 miu Vesanoid tablets 10mg Xeloda tablets 150 mg Xeloda tablets 500 mg

The patient must have no prescription coverage, have reached their cap, or cannot afford the co-payments and must meet undisclosed income requirements. If the patient has any type of insurance, the program will first verify non-coverage prior to faxing an application.

The patient, or their doctor or social worker must call for a prescreening. The application will then be faxed to the patient’s doctor. The patient and their doctor must complete the application and submit by fax or mail. The patient’s doctor will be notified of the eligibility determination.

Upon eligibility determination, up to a 90-day supply of the medication will be sent to the patient’s home or doctor. The program will contact the doctor to arrange for refills. A new application is required every 12 months.

VESANOID is for the induction of remission only.

N/A Approved by the FDA for the induction of remission in patients with acute promyelocytic leukemia (APL), French-American-British (FAB) classification M3 (including the M3 variant), characterized by the presence of the t(15;17) translocation and/or the presence of the PML/RARalpha gene who are refractory to, or who have relapsed from, anthracycline chemotherapy, or for whom anthracycline-based chemotherapy is contraindicated. VESANOID is for the induction of remission only. VESANOID is approved by the FDA for the induction of remission in patients with acute promyelocytic leukemia (APL), French-American-British (FAB) classification M3 (including the M3 variant), characterized by the presence of the t(15;17) translocation and/or the presence of the PML/RARalpha gene who are refractory to, or who have relapsed from, anthracycline chemotherapy, or for whom anthracycline-based chemotherapy is contraindicated.

Vidaza
Azacitidine
Pharmion Corporation

Vidaza Patient Assistance Program N/A http://www.vidaza.com/corporateweb/vidazaus/homeB.htm?Content=PatientAssistance (866)742-7048, option 4 (866)369-4343 Vidaza powder for solution 100mg

The patient must be a US resident, have no prescription insurance, be ineligible for any government programs and meet undisclosed income guidelines. The application can be downloaded from the website or requested by telephone. If requested by phone, the application will be faxed to the recipient. The patient and their doctor must complete the application and submit by fax. Both patient and doctor are notified in writing of the eligibility determination.

Upon eligibility determination, the requested amount is sent to the patient’s doctor. The program will contact the doctor to arrange for refills. A new application is required every six months.

Vidaza Patient Assistance Program
Approved by the FDA to treat myelodysplasia syndromes (MDS).
The patient must: be a US resident; have no prescription coverage for the medication; have an income at or below 200% of the Federal Poverty Level. For the purposes of eligibility, prescription discount cards are not considered insurance. If patient has reached their prescription coverage cap, they may still be eligible for participation in this program.

The patient's doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

The doctor can request an application by telephone, and the application will be faxed to the doctor's office. The patient and their doctor must complete the application and submit it by fax. The doctor is notified of the eligibility determination, which is usually made within 48 hours.

Once eligibility is determined, the medication will be sent to the doctor's office. A refill request form is included with each shipment and must be completed and submitted to receive a refill. A new application is required every 6 months.

The patient and their doctor are notified of the eligibility determination, up to a 90-day supply of the medication will be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

Once the eligibility determination has been made, the medication will be sent to the doctor's office. The doctor will contact the program to request refills when they are needed. A new application is required every 6 months.

The doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Upon eligibility determination, the patient or their insurance, or social worker must call for a pharmacy. The application will then be faxed to the patient's home or doctor. The patient and their doctor must complete the application and submit it by fax or mail. The patient's doctor will be notified of the eligibility determination. Once eligibility is determined, the medication will be sent to the doctor's office. A refill request form is included with each shipment and must be completed and submitted to receive a refill. A new application is required every 12 months.

The patient and their doctor are notified of the eligibility determination. The patient must call for a prescreening. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination.

Once eligibility is determined, the medication will be sent to the doctor's office. A refill request form is included with each shipment and must be completed and submitted to receive a refill. A new application is required every 6 months.

The doctor must call to request the application, which will then be sent to the doctor's office. The form must be completed by the patient and their doctor and can be submitted by fax or regular mail. The doctor will be notified of the eligibility determination. Once eligibility is determined, the medication will be sent to the doctor's office. A refill request form is included with each shipment and must be completed and submitted to receive a refill. A new application is required every 6 months.
Zevalin

Zevalin Results

N/A

PO Box 222007
Charlotte, NC 28222-2907

(800)386-9997
(888)13-8085

Zevalin Kit-indium-111

The patient must be a US resident. The program is based on undisclosed guidelines. The application can be requested by phone and will be faxed to the recipient. The patient and their doctor must complete the application and submit by fax or mail. The patient's doctor will be notified of the eligibility determination, which is normally made within 48 hours.

Upon eligibility determination, the medication is sent in one treatment cycle at a time to the patient's doctor. This is a one-time program.

Approved by the FDA for the treatment of patients with relapsed or refractory low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with Rituximab refractory follicular non-Hodgkin's lymphoma.

Zinacef

Denzaloxone

Pfizer, Inc.

First Resource Program for IV Medications

Healthcare Solutions

http://www.pfizerhealth.com/ProgramList.aspx

PO Box 239
San Bruno, CA 94066-0339

(877)444-5675
(800)08/3400

Camposol insertion Elleos injection 50 mg/25 ml Elastro solutio injection 200 mg/100 ml Tiamycin injection Zinecard 50mg Zinacef powder for injection 250mg

The patient must be a US resident, have no prescription coverage for the medication, and meet undisclosed income guidelines. Patients who are eligible for Medicare Part D but who have not already enrolled may still be eligible for participation in this program.

The doctor, patient, social worker or patient advocate must call for a prescreening. The application is sent to either the doctor or patient depending on the institution. The patient's doctor will contact the doctor to arrange for refills. A new application with documentation is required every 12 months.

Approved by the FDA for the treatment of low-grade, follicular, or transformed B-cell non-Hodgkin's lymphoma, including patients with Rituximab refractory follicular non-Hodgkin's lymphoma.

Zoladex

Zoleadon Acetate

Astellas and Exmoracu

is

AstraZeneca Cancer Support Network

http://www.astraZeneca.com/content/patientAssistanceProgram/Hotline

PO Box 66550
St. Louis, MO 63166-6550

(888)392-9716

N/A

Amidax tablets 5mg Faslodex injection 5ml Zoladex depot 3.6mg (monthly) Zoladex depot 10.8mg (every 3 months)

The patient must be a US resident or have a valid visa, not have prescription insurance, be ineligible for any government programs, and have an income at or below 250% of the Federal Poverty Level. Patients who are eligible for Medicare Part D but who have not enrolled may still be eligible for this program.

The prescription may be faxed from the website or requested by telephone. If requested by telephone, the requester will receive the application by fax. The patient and their doctor must complete the application and submit it by mail. If a patient is determined ineligible, both the patient and doctor will be notified. Delivery of medication may take 3-6 weeks.

Once eligibility has been determined, a 90-day supply will be sent to the doctor. The patient or their doctor must contact the program for refills. A new application with documentation is required every 12 months.

Approved by the FDA for the treatment of advanced carcinoma of the prostate. Stage B2-C Prostate Cancer. ZOLADEX is indicated for use in combination with flutamide or leuprolide for the management of locally confined Stage T2b-T4 (Stage B2-C) carcinoma of the prostate.

Zometa

Zoledronic Acid

Novartis Pharmaceuticals

Novartis Oncology Reimbursement Hotline

http://www.novartis.com/revant/slap/pap_oncology_enrol.jsp

(800)727-2254, option 2
(888)8914924

Femara tablets 2mg Osevocse tablets 100mg Flutamide Zometa injection 2mg Zometa injection 4mg Zometa injection 8mg Zometa injection 16 mg

The patient must have no prescription coverage for the medication and must meet undisclosed income guidelines. Medicare Part D is considered prescription coverage, so if a patient qualifies for Medicare Part D, they cannot obtain assistance from this program.

The application can be requested by telephone and will be faxed to the recipient. The application is a two-part process. The first application contains basic information and does not require signatures. The patient and their doctor must complete the second application, which requires signatures and the patient's proof of insurance. The completed application must be submitted by fax. Both the patient and their doctor are notified of the eligibility determination.

Upon eligibility determination, the medication is sent to the patient's home or their doctor. The program will contact the patient's doctor to arrange for refills. A new application is required every 12 months.

Approved by the FDA for the treatment of patients with hypercalcemia (high blood levels of calcium) caused by malignant tumors. It is also approved to be used together with other drugs to treat multiple myeloma and cancers that have spread to the bone.
Zyloprim
Allopurinol
Express Scripts Specialty Distribution Services
Rx Outreach Medications
http://www.rxoutreach.com/
PO Box 66536
St. Louis, MO 63166-6536
(800)769-3880
N/A
Tamoxifen citrate tablets 10 mg
Tamoxifen citrate tablets 20 mg
Allopurinol tablets 100 mg
Allopurinol tablets 300 mg

Applications can be requested by phone or downloaded from the website, and will be sent out by fax or mail. The patient and their doctor must complete the application and submit it by mail. The patient will be notified of the eligibility determination.

Upon eligibility determination, up to a 90-day supply will be sent to the patient’s home or doctor. The patient must contact the program to arrange for refills. A new application is required every 12 months.

Approved by the FDA for the management of patients with leukemia, lymphoma, and solid tumor malignancies who are receiving cancer therapy which causes elevations of serum and urinary uric acid levels and who cannot tolerate oral therapy.