paxmanUSA.com

PAXMAN HUB ENROLLMENT FORM

PAXMAN HUB
PO BOX 29264
PHOENIX AZ 85038-9264
PHONE: 8445PAXMAN
FAX: 888-358-0410

PLEASE COMPLETE THE INFORMATION BELOW AND FAX TO **888-358-0410**

Requested Services (Check all that apply):

Financial Assistance Requested: ☐ Yes ☐ No
Financial Assistance Approved: ☐ Yes ☐ No
Foundation Name:.....
HCP to pay for: ☐ Cap ☐ Treatment days
Patient to pay for: ☐ Cap ☐ Treatment days
Household Size:.....
Total Gross Monthly Income:.....

Insurance Data

Insurance Name:.....
Insurance Phone:.....
Policy:.....
Group:.....
Policy Holder's Name:.....
Policy Holder's DOB:.....
Policy Holder's SSN:.....

STEP 1 PATIENT INFORMATION

First Name: | MI: | Last name:

Address:

City: | State: | Zip:

DOB (MM/DD/YYYY):

Gender: ☐ Male ☐ Female

Race: (Select all applicable)
White ☐
Asian ☐
Black or African American ☐
American Indian or Alaska Native ☐
Native Hawaiian or Other Pacific Islander ☐

Home Phone Number:

Ethnicity:
(Select only one box)
Hispanic or Latino ☐
Not Hispanic or Latino ☐

Cell Phone Number:

Preferred Number to Call: ☐ Home Phone ☐ Cell Phone

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Email Address:
Tick box to opt-in to receive educational and marketing material: ☐

STEP 2 PRESCRIBER INFORMATION

Prescriber First Name: | Prescriber Last Name:

Facility/Practice Name:

Practice Address:

City: | State: | Zip:

NPI #: | State License #:

Practice Contact First and Last Name:

Practice Contact Email Address:
Tick box to opt-in to receive educational and marketing material: ☐

Practice Contact Phone #: | Practice Contact Fax #:

Prescriber Email Address:
Tick box to opt-in to receive educational and marketing material: ☐

PAXMAN PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING

I certify that (i) the information contained on this form is accurate to the best of my knowledge and (ii). I am the prescribing healthcare provider of Paxman Scalp Cooling Cap to the previously identified patient and that I provided the patient with the description of the Paxman program. For purposes of transmitting this prescription, I authorize Paxman US, Inc. and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy.

Dispense as Written: ☐ *If this form does not meet your state's requirements for a valid prescription, please attach a valid prescription (or eprescribe).*

Prescriber Signature: | Date:

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Patient Full Name | Patient DOB | Prescriber Name | NPI#

STEP 3 TREATMENT AND PRESCRIPTION INFORMATION AND PHYSICIAN AUTHORIZATION

ICD-10 Diagnosis Code:

Additional Diagnosis Code:

Additional Diagnosis Code L65.9

Therapy Start Date:

Directions: **Use as directed**

Quantity: **One**

Cap/Cover Size (REQUIRED for New Patients only): ☐ S/S ☐ M/S ☐ M/M ☐ L/L

Prescribed Treatment Days: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Other No. of Treatment Days:

☐ Refill (check corresponding treatment days needed. Do not include initial treatment days received)

Date of refill: Refill Treatment Days ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Date of refill: Refill Treatment Days ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Date of refill: Refill Treatment Days ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

☐ Refill (if more than treatment days is needed, check corresponding treatment day below)

Date of refill: Refill Treatment Days ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23

Date of refill: Refill Treatment Days ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23

Date of refill: Refill Treatment Days ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23

☐ Refund (check completed treatment days)

Completed Treatment Days: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

PATIENT CONSENT IS ALSO MANDATORY FOR PROCESSING

I authorize my health care providers, pharmacies, and health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal Information") to Paxman, its affiliates, business partners, service providers, third-party contractors, and agents (together, the Paxman Hub) so that the Paxman Hub can provide me with the Patient Support Services available for the Paxman Scalp Cooling Cap prescribed by my HCP on this Enrollment Form to (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with this product including to locate alternative funding sources , (ii) coordinate my receipt of, and payment for this product, (iii) facilitate my access to this product, (iv) provide me with information about this product and management programs and educational materials, (v) manage the Patient Support Services, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Patient Support Services. I give permission to the Paxman Hub to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Paxman in exchange for disclosing my Personal Information to Paxman and/or for providing me with therapy support services. I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I can refuse to sign this Authorization and that this will not affect my treatment, insurance coverage, or eligibility for benefits or Paxman products; however, if I do not sign this Authorization, I will not be able to receive Patient Support Services. I also may revoke this authorization at any time in the future by writing to PO Box 29264, Phoenix, AZ 85038-9264. If I revoke this authorization, I may no longer be eligible to participate in the Patient Support Services. If I revoke this authorization, the Paxman Hub will stop using or sharing my information (except as necessary to end my participation in the Services) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five years after the date of my signature, unless I revoke it earlier. I also understand that the Patient Support Services may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

Patient Signature: Date:

By signing the Release of Information section, I authorize the Paxman Hub to release my Paxman Scalp Cooling case details with: