GSK REIMBURSEMENT RESOURCE CENTER

The *BEXXAR*® THERAPEUTIC REGIMEN (Tositumomab and Iodine I 131 Tositumomab)

PATIENT INFORMATION FORM

Please fax completed Form to: (866) 216-5292 **Phone: (800) 745-2967**

Patient's Last Name ______ First ______ Middle Initial ______ Social Security Number ______ Date of Birth ______

Street Address ______ City ______ State ______ ZIP Code ______ Home Telephone ______

Primary Insurance		**Secondary Insurance**
Company Name	______	______
Telephone	______	______
Subscriber's Name	______	______
Relationship to Patient	______	______
Social Security #	______ Date of Birth ______	______ Date of Birth ______
Policy ID #	______ Group # ______	______ Group # ______
Employer	______	______

Please attach *GSK Reimbursement Resource Center – Patient Authorization to Release and Disclose Medical Information Form*

(If you do not have the patient authorization form, please call (800) 745-2967 to request it. We will not be able to provide patient-specific reimbursement services without the signed authorization.)

Patient Medical Information

Name of Treatment Site where *BEXXAR* will be administered: ______

Administering treatment site contact name ______ Contact Telephone # ______

***BEXXAR* Therapeutic Regimen will be provided** [ ] Outpatient Hospital [ ] Inpatient Hospital [ ] Free Standing Facility

Primary Diagnosis (Please provide actual code or codes): ______

Previous Treatment(s): ______

______

Justification for *BEXXAR* Therapeutic Regimen (check all that apply)

[ ] Statement of Medical Necessity attached [ ] Other (please specify) ______

Authorized Prescribing Physician's Signature ______ Date ______

Authorized Prescribing Physician's Name (Please print) ______

Referring Physician's Name (Please Print) ______ Telephone # ______

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