Medical Care Provider Statement

The information below is required to process a Patient Services, Inc (PSI) financial assistance application. This form must be completed by the applicant's medical provider and may be submitted to PSI via secure portal upload, encrypted email, fax, or mail.

Patient Name: _____

Date of Birth: _____ PSI Patient ID: _____

Diagnosis

Please indicate the patient's diagnosis for which you are treating.

- ❑ Alpha-1 Antitrypsin Deficiency
- ❑ Circadian Rhythm Disorder
- ❑ CIDP
- ❑ Complement Mediated Diseases
  - ❍ aHUS
  - ❍ PNH
  - ❍ CAPS
  - ❍ STEC-HUS
  - ❍ AMR
  - ❍ CAD
- ❑ Corneal Cystine Crystal Accumulation in Cystinosis
- ❑ Chronic Myelogenous Leukemia (CML)
- ❑ Cystic Fibrosis
- ❑ Exocrine Pancreatic Insufficiency (EPI) and Underlying Conditions
- ❑ Fabry
- ❑ Gaucher's Disease
- ❑ Gastrointestinal Stromal Tumors
- ❑ Glanzmann's Thrombasthenia
- ❑ Hereditary Angioedema
- ❑ Hypoparathyroidism
- ❑ Idiopathic Pulmonary Fibrosis
- ❑ Kidney Stones
- ❑ Lysosomal Acid Lipase Deficiency
- ❑ MPS1
- ❑ Parkinson's Disease
- ❑ Pompe
- ❑ Primary Immune Deficiency
- ❑ Pseudobulbar Affect
- ❑ vonWillibrands *(specify type below)*
  ❍Type 1 ❍Type 2 ❍Type 3
- ❑ Other _____

Bleeding Disorder (*specify below*): ❑ Hemophilia ❑ Hemophilia with Inhibitors
Factor Deficiency: ❍ 7 ❍ 8 ❍9 ❍10 ❍ 11 ❍13 Severity: ❍Mild ❍Moderate ❍Severe

Breast Cancer Screening: *specify reason(s) for prescribing MRI below.*

- ❑ High genetic predisposition to breast cancer through BRCA positive testing
- ❑ Verifiable family history

Prescribed Treatment

Please list the FDA approved product(s) that the applicant's medical provider has prescribed for the diagnosis listed above, based on his or her independent medical judgment as to the clinical best interest of the patient. If the patient is not currently being treated on-label, please provide the reason (i.e. undergoing diagnostic testing, etc.) under the Product section.

Product	Dosage	Frequency	Route
_____	_____	_____	_____
_____	_____	_____	_____

Certification

By signing this form, I certify that the patient listed above has been diagnosed by his or her medical provider with the condition listed above. The patient is currently being treated for this condition with the FDA-approved products listed on this form. I certify that the patient's diagnosis and treatment were determined solely and independently by his or her medical provider prior to the submission of this form or any communications with PSI regarding the possibility of financial assistance. I understand that financial assistance is available for any underlying and FDA-approved treatment for the condition listed above. I certify that the treatment selected was determined solely based on the clinical best interest of the patient.

Physician Information

Physician's Name (please print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Name of person completing form (please print): _____

Title of person completing form (please print): _____

Physician Signature: _____ Date: _____ / _____/ _____