Patient Enrollment Form

Pr Synacthen® Depot patient support program

Reimbursement Support Consent

Drug benefit eligibility for medications such as Synacthen® Depot from your Group Health Drug Plan, Private Medical Insurance, or Provincial Formulary Exemption Processes may be difficult to access and be conditional.

Medicum is a leading Canadian patient support service that works on your behalf to help with your drug benefit eligibility for Synacthen® Depot and other benefits that are important to the successful management of your condition.

Our patient benefit associates will thoroughly investigate and assist you with your request for drug benefit eligibility. This is a free and confidential service for you and is supported by the makers of Synacthen® Depot.

INSTRUCTIONS: You and your attending physician should fill in the required information on this enrollment form and fax back to Medicum at the number below. You will receive a communication from Medicum updating you on your eligibility status shortly after the document has been faxed back for evaluation. If you have any questions, Medicum can be reached at 1-866-424-8051.

Enrollment & Consent Form – Medical Insurance Investigation Authorization

To Whom It May Concern,

I hereby authorize Medicum Patient Assistance Program Inc. to investigate and determine on my behalf or that of my spouse or dependent, any and all information related to my medical insurance coverage and its conditions as it relates to medications or other medical benefits associated to my medical treatment. I acknowledge that in investigating my full benefit potential, Medicum will need to contact my insurer, or that of my spouse as well as my physician. In order to assist Medicum with my file, I hereby provide the following background information:

Patient's Group Health Plan Or Insurance Membership Authorization

Patient Name:	Plan Member:
Date of Birth:	Member Date of Birth:
Address:	Employer:
City: Province:	Group Health Insurer:
Postal Code: Telephone:	
Attending Physician:	Policy #:
Physician's Telephone:	Group #: I.D.#
Physician's Fax:	Employee Status: ☐ Active ☐ Retired
Physician's e-mail: (optional)	

- *I hereby grant my full consent in allowing Medicum to access my medical insurance coverage eligibility on my behalf.*
- *I grant permission to Medicum to assist me in dealing with my insurer or act on my behalf.*

Applicant's Authorization: _____ Date: _____

(Please sign here)

Physician's Notice Of Medical Necessity Authorization

- *I hereby acknowledge that I am the patient's attending physician.*
- *I confirm that the patient has been prescribed Synacthen® Depot (tetracosactide) by me in accordance with its intended use as outlined in the product monograph.*

Physician's Authorization: _____ Date: _____

(Please sign here)

Please fax or send in the completed form to:

Fax : 1-877-787-3376 (Toll-Free)

Mail: Synacthen® Depot Patient Assistance Program
472F Main Road
Hudson, QC J0P 1H0