CLEAR FORM

pennsylvania
DEPARTMENT OF HEALTH

Special Pharmaceutical Benefits Program Application

The Special Pharmaceutical Benefits Program (SPBP) is administered by the Pennsylvania Department of Health. For more information regarding program eligibility requirements, income limits, or covered services, go to www.health.pa.gov/spbp.

For questions about the application or enrolling, call 1-800-922-9384 or send your questions to SPBP@pa.gov.

1 Applicant Information

Last name _____ First name _____

Middle initial _____ Suffix (Sr., Jr., etc.) _____

SPBP ID number (if known) _____ Preferred language

- ○ English
- ○ Spanish
- ○ Other _____

Home address _____ Include proof of residency with your application.

City _____ State _____ Zip _____

Provide your preferred mailing address below if it is different from your home address. It must be a Pennsylvania address.

Preferred mailing address _____

City _____ State _____ Zip _____

Date of birth _____

Social Security number _____ Include proof of your Social Security number with your application.

☐ I do not have a Social Security number.

Home phone number _____ Mobile phone number _____

Gender (check one)

- ○ Male
- ○ Female
- ○ Transgender male to female
- ○ Transgender female to male

Ethnicity (check one)

- ○ Hispanic/Latino
- ○ Non-Hispanic

Race (check one)

- ○ Black/African-American
- ○ White
- ○ Asian
- ○ American Indian/Alaska Native
- ○ Native Hawaiian/Pacific Islander
- ○ Other _____

Has your CD4 count ever dropped below 200 cells/µl?

- ○ Yes
- ○ No
- ○ Not sure

If you are female, complete the following question(s).

Were you pregnant at any time during the last six months?

- ○ Yes
- ○ No

If yes, did your pregnancy result in a live birth?

- ○ Yes
- ○ No

2 Other Health Care Coverage

Do you currently have any other health care coverage?
- ○ Yes (Complete the insured section below and provide a copy of your insurance card with your application.)
- ○ No (Complete the uninsured section below.)

Insured section

Check each type of coverage that you currently have:

- ☐ Medicare Part A
- ☐ Medicare Part B
- ☐ Medicare Advantage (HMO)
- ☐ Other (Write in plan name.) _____
- ☐ Medicare Part D
- ☐ Medicaid/Medical Assistance
- ☐ U.S. Veterans Administration

If you have insurance, does it cover prescription medications? (If you have a separate prescription card, provide a copy of each card.)
- ○ Yes
- ○ No

Uninsured section

If you do not have insurance, please check the reason why.
- ○ Non-citizen
- ○ Cannot afford the cost/premiums
- ○ I decided not to apply for other health care coverage.
- ○ Other _____

Have you applied for Medicaid in the last 12 months?
- ○ Yes
- ○ No

If yes, what is the status of your Medicaid application?
- ○ Approved
- ○ Denied (Provide the Medicaid denial notice with application.)
- ○ Application currently under review

3 Family Members

Provide information for all family members who live in your household. Family members include your spouse and your children under 21 who reside in the same household; if you are under 21, include your parents if you reside in the same household. (Note: If you are a single/unmarried applicant 21 or older without dependents, do not list any family members.)

Spouse/family member #1

Name (last, first, middle initial, suffix) _____ Date of birth _____

Social Security number _____ Sex: ○ Male ○ Female ○ Transgender

Relationship to you: ○ Spouse ○ Child under 21 ○ Parent of child under 21

Family member #2

Name (last, first, middle initial, suffix) _____ Date of birth _____

Social Security number _____ Sex: ○ Male ○ Female ○ Transgender

Relationship to you: ○ Child under 21 ○ Parent of child under 21

Family member #3

Name (last, first, middle initial, suffix) _____ Date of birth _____

Social Security number _____ Sex: ○ Male ○ Female ○ Transgender

Relationship to you: ○ Child under 21 ○ Parent of child under 21

If necessary, attach a separate sheet listing additional family members.

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4 Household Income

Check each type of income received by you and your family members in the same household. Family members include your spouse and your children under 21 who reside in the same household; if you are under 21, include your parents if you reside in the same household. (Note: If you are a single/unmarried applicant 21 or older without dependents, do not check any family members.)

Type of income	Income received		
	Self	Spouse	Family member(s)
1. Salary/wages/bonus/commissions (before deductions)	☐	☐	☐
2. Unemployment compensation or veterans benefits	☐	☐	☐
3. Social Security retirement/survivor's benefits/SSI	☐	☐	☐
4. Other pensions or retirement	☐	☐	☐
5. Social Security disability or other disability income	☐	☐	☐
6. Worker's compensation or sick benefits	☐	☐	☐
7. Alimony or child support	☐	☐	☐
8. Dividends/interest/royalties/capital gains	☐	☐	☐
9. Rental income (gross income minus expenses)	☐	☐	☐
10. Public assistance (Do not include food stamps or LIHEAP.)	☐	☐	☐
11. Business/self-employed/partnerships	☐	☐	☐

- Provide proof of income for yourself, spouse, and family member(s).
- Examples of acceptable proof of income for gross salary/wages:
  - Pay stubs for at least four weeks (one month) of income
  - Previous year IRS 1040, PA 40, PA 1000, or local tax return (Tax returns must be signed even if filed electronically.)
  - Previous year W-2 form
  - Wages for small jobs: A non-notarized letter is acceptable.
  - Letter from HUD (Housing and Urban Development)
  - Written letter/document from employer with four weeks (one month) of income
- For other types of income such as unemployment compensation, Social Security, pensions, etc., submit a copy of the award letter or other official documentation as proof.
- If you are self-employed, you must provide a copy of your most recent signed IRS 1040 tax return, including Schedule C.
- If you do not receive any income, you must provide a letter stating that you currently do not have any income and explain how you meet your daily needs. The letter must be signed and dated.

5 Case Manager Information

If you have a case manager, complete this section.

Name of case manager _____ Case manager phone number _____

Case manager email _____

Name of agency _____ Address of agency _____

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6 Authorization for Disclosure of HIV-Related Information to Specified Persons

SPBP will not communicate with anyone other than you or your health care professional (i.e., clinician or case manager) regarding your information, unless this document is completed.

List all individuals below that you grant consent for SPBP to communicate with.

1. I _____ (print applicant's name) am applying or re-applying for benefits from the Special Pharmaceutical Benefits Program (SPBP) of the Department of Health.
2. I understand that SPBP may need information about me or may have to discuss my circumstances with me or other persons in order to determine whether or not I am eligible for benefits and to resolve issues regarding my participation in SPBP.
3. I understand that my information is or may be confidential information under the Confidentiality of HIV-Related Information Act.
4. I understand that in order for SPBP to have discussions about my circumstances or to exchange information about me with persons other than me or my health care provider and case manager, I will need to give SPBP and its staff permission to talk to those persons.
5. I understand that signing this document will provide that permission for six months, unless I tell SPBP I do not want them to continue talking with a specific person or unless I say that a specific event will cause me to withdraw my permission.
6. I understand I will need to sign a new authorization each time I reapply for the program.
7. I understand that SPBP will not discuss my circumstances with persons other than me or my health care provider and case manager without my permission and that this could impact my ability to apply for the program.

I authorize the Special Pharmaceutical Benefits Program of the Pennsylvania Department of Health and its affiliates (Department of Aging and Magellan Health Services) to disclose information related to my HIV status and my proposed or ongoing participation in the Special Pharmaceutical Benefits Program for the purpose of enrolling, re-enrolling, or obtaining benefits that are or may be due to me under that program to any of the following persons (if necessary, attach a separate sheet listing additional individuals):

Full name and title or name of organization, agency, etc.
#1 _____

Address _____ Phone number _____ Email address _____

Full name and title or name of organization, agency, etc.
#2 _____

Address _____ Phone number _____ Email address _____

Full name and title or name of organization, agency, etc.
#3 _____

Address _____ Phone number _____ Email address _____

This authorization may be withdrawn at any time before the actual disclosure takes place. This authorization will **expire six months from the date of my enrollment** or when I am no longer participating in the program, if I have not withdrawn it earlier.

I have read or someone has read and explained this authorization to me.

Print applicant's name
(individual applying for SPBP) _____ SPBP ID number (if known) _____

SIGN HERE Applicant's signature
(or legal guardian) _____ Date _____

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7 CD4 Count and Viral Load Information

Will you be providing a copy of your CD4 count and HIV-1 viral load lab results dated within the last year?

- ○ Yes (Submit copies of your lab results with your application and skip to section 8.)
- ○ No (Have your prescribing clinician complete the CD4 count and HIV-1 viral load information below.)

CD4 count _____ cells/µl Draw date _____

☐ Check here if applicant is not clinically indicated to have his/her CD4 count monitored within the last year based on recommendations in the current "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents."

HIV-1 viral load _____ copies/ml Draw date _____

Prescribing clinician's name (printed) _____ NPI number _____

Clinician's phone number _____

Name of hospital/clinic _____ Address of hospital/clinic _____

SIGN HERE Prescribing clinician's signature _____ Date _____

8 Confirmation of HIV Diagnosis by a Licensed Clinician

1. If this is your first time applying to SPBP, give this section to your licensed clinician to complete. Your clinician must include his/her printed name, NPI number, signature, and date below.
2. This section does not need to be completed for applicants re-enrolling in SPBP.

Applicant's name (printed) _____ SPBP ID number (if applicable) _____

Date of patient's last appointment _____

Based on my personal knowledge and evidence from the medical record, by providing my signature below I certify that appropriate laboratory tests conclude the patient named in the application has a diagnosis of HIV. I understand that payments for specific HIV medications will be sought from state and federal funds under the Special Pharmaceutical Benefits Program. The misrepresentation, concealment, or falsification of information concerning the diagnosis of the applicant may subject the provider to civil or criminal sanctions.

Prescribing clinician's name (printed) _____ NPI number _____

SIGN HERE Prescribing clinician's signature _____ Date _____

All information submitted will only be used to administer the Special Pharmaceutical Benefits Program. If you have questions about completing this section, please call 1-800-922-9384 or send an email to SPBP@pa.gov.

Return the completed form to:
Department of Health
Special Pharmaceutical Benefits Program
P.O. Box 8808
Harrisburg, PA 17105-8808
Or email to: SPBP@magellanhealth.com
Or fax to: 888-656-0372

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9 Certification Statement and Applicant's Signature

My responsibilities

I understand that this application is a legal document and it is my responsibility to:

1. Comply with all SPBP policies as a condition of my continued eligibility;
2. Submit a re-enrollment application for review of my information every six months;
3. Update my address, insurance, and income information with supporting documentation when they occur;
4. Act in a professional and responsible manner when communicating with SPBP representatives; and
5. Forgo and promptly send to SPBP any payment from any insurance company for any amount which has been paid by the SPBP on my behalf.

I understand and agree that failure to abide by any aforementioned responsibilities will lead to termination or a declined application.

My benefits

Upon approval of this enrollment application I will have the following benefits:

1. Assistance with costs for SPBP formulary covered medications;
2. Assistance with costs for SPBP specified laboratory services only if I have no other insurance coverage; and
3. Assistance with Medicare Part D enrollment in SPBP partnering plans and monthly premiums (if applicable).

My appeal rights

If my enrollment or re-enrollment application is denied or my benefits canceled, I have the right to appeal the decision. (Information on how to appeal an adverse decision will be provided by SPBP in a separate letter.)

I certify that the information I have given on this application is true, correct, and complete. I agree to cooperate in documenting the information I have given or providing additional information to support my application as required by the department. I understand that my eligibility may be denied if I fail to provide accurate or complete information or fail to cooperate with the SPBP as requested. I further understand that the SPBP may terminate my eligibility at any time if the information I have provided is determined to be false or incomplete.

SIGN HERE Applicant's signature (or legal guardian) _____ Date _____

All information submitted will be kept confidential and will only be used to administer the Special Pharmaceutical Benefits Program. Information is shared with claim processing vendors for the purpose of paying pharmaceutical and laboratory claims, if applicable, and for coordination of benefits.

If you need help completing this application, please call 1-800-922-9384 or send an email to SPBP@pa.gov.

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Application Checklist (additional information to submit to SPBP with your application)

Checklist for individuals enrolling in SPBP for the first time

- ☐ Include proof of residency.
- ☐ Include a copy of Social Security card.
- ☐ Include a copy of the front and back of health/prescription insurance card(s) [if applicable].
- ☐ Include Medicaid denial notice (if applicable).
- ☐ Include proof of household income.
- ☐ Provide section 8 "Confirmation of HIV Diagnosis by a Licensed Clinician" form to prescribing clinician to complete, sign, and return to SPBP.

Checklist for individuals re-enrolling in SPBP

- ☐ Include proof of residency.
- ☐ Include a copy of the front and back of health/prescription insurance card(s) and insurance termination notices (if applicable).
- ☐ Include Medicaid denial notice (if applicable).
- ☐ Include proof of household income.
- ☐ Provide a copy of CD4 count and HIV-1 viral load lab results dated within the last year to SPBP (OR give section 7 "CD4 Count and Viral Load Information" to prescribing clinician to complete, sign, and return to SPBP).

Return the completed application and copies of documentation to:

pennsylvania
DEPARTMENT OF HEALTH

Special Pharmaceutical Benefits Program
P.O. Box 8808
Harrisburg, PA 17105-8808
Or email to: SPBP@magellanhealth.com
Or fax to: 888-656-0372

End of SPBP application