



THE HEMOPHILIA ALLIANCE, INC.

MEMBERSHIP:

- New Member Application
- Updated Information

PLEASE PRINT OR TYPE

HTC Name:		Contact Name:	
Contact E-mail:			
Address:			
City:		State:	Zip:
Phone: ()		Fax: ()	
How did you hear about the Hemophilia Alliance?			

PLEASE TELL US MORE ABOUT YOUR PROGRAM:

Is Your HTC:

Based in a Hospital? Yes No

Is Your Out-Patient Factor Program:

340B only 340B and non-340B (Dual Inventory)

Do You Have a Contract Pharmacy: Yes No

Do You Use 340B Drugs for Medicaid Beneficiaries?

Yes (Please make sure you have submitted your Medicaid Provider Number to the Pharmacy Affairs Branch. If you have questions about this, please call the number at the end of this form.)
 No

Dues can be paid in two equal installments in January and July and will be assessed as follows:

- Start-up: no clotting factor sold in previous 12 mths. but HTC is starting a program - \$1,000/yr**
- Medium: HTC that sold <10 million units of clotting factor in previous 12 mths - \$5,000/yr**
- Large: HTC that sold >10 million units of clotting factor in previous 12 mths - \$9,000/yr**

Dues are pro-rated based on when in the year you join the Hemophilia Alliance

Please make your check payable to the Hemophilia Alliance, Inc. and mail it to:

1758 Allentown Road # 183, Lansdale, PA 19446

Attention: Joe Pugliese

If you have questions about this form, please call Joe Pugliese at 215-279-9236. Please e-mail the completed form to joe@hemoalliance.org or fax it to 215-279-8679 Thank you!