AMERICAN REGENT IV IRON PATIENT ASSISTANCE PROGRAM
ENROLLMENT APPLICATION

Requested Product: ☐ **VENOFER®** (iron sucrose injection, USP) ☐ **INJECTAFER®** (ferric carboxymaltose injection)

Patient Information

Patient's Name: ________________________ Case Number: ______________
Social Security Number: ______________ Sex: ______________ Date of Birth: ______________
Address: ____
City: ______________ State: __________ Zip Code: ______________
Daytime Phone: ______________ Evening Phone: ______________
Primary Diagnosis:______________ Secondary Diagnosis:______________ Is this patient current receiving dialysis treatment? ☐ Yes ☐ No

Provider Information

Physician Name: ____
Contact Person (other than physician): ________________________
Facility/Practice Name: ________________________________
Address (no PO boxes please): ________________________
City: ______________ State: __________ Zip Code: ______________
Daytime Phone: ______________ Fax: ______________

Insurance Information

Please provide data on insurers that provide health insurance benefits to this patient:

Insurer	Status			Plan Name	Effective Date
☐ Medicare	☐ Approved	☐ Pending	☐ Denied	____________	___/___/___
☐ Medicaid	☐ Approved	☐ Pending	☐ Denied	____________	___/___/___
☐ Private	☐ Approved	☐ Pending	☐ Denied	____________	___/___/___
☐ Other	☐ Approved	☐ Pending	☐ Denied	____________	___/___/___

☐ Patient does not have and is not eligible for any public health insurance.

Financial Information

Total annual household income (from most recent federal tax return): $______________ Number in Household:______

Patient Certification and Consent

I would like to receive Venofer® or Injectafer®, as prescribed by my physician and indicated above, free of charge from American Regent, Inc. (AR). I do not have, nor am I eligible for, any private or public health insurance or any other form of assistance with my medical expenses.

I certify that the above information is correct to the best of my knowledge, and agree to notify the program of any changes. I understand that this information will not be used for any other purpose unless I give written consent, unless it is required by the government, or unless AR removes my name and any other identifying information.

I understand that AR reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. I also understand that, although Venofer® or Injectafer® may be given to me without cost now, this does not mean I will be entitled to receive it without cost indefinitely.

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Patient Signature Date

Provider Certification Statement

I have determined that Venofer® or Injectafer®, as indicated above, is medically appropriate for the above named patient.

I have received the consent of the above named patient to provide this information and to request assistance on his or her behalf.

I agree to allow American Regent, Inc. (AR) or an authorized AR representative to review the medical, financial, and insurance records for Program patients at any time for the purpose of verifying the patient's medical, financial and insurance status and I have received the consent of the above named patient to do so.

I understand that AR reserves the right to modify or discontinue this Program with respect to any patient, or in its entirety, at any time.

I understand that no third party or patient may be charged for any Venofer® or Injectafer® for which replacement product is sought under this Program.

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the Program of any changes of which I become aware, which could affect the patient's eligibility status.

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Provider Signature Date

American Regent, Inc. (AR) reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. AR also reserves the right to make an independent determination of medical indigence in all cases.

Please send this completed form to: American Regent IV Iron Patient Assistance Program
c/o InTeleCenter, P.O. Box 4280, Gaithersburg, MD 20885-4133. Phone: 877-448-4766 Fax: 240-632-3805