

**Venofer® (iron sucrose injection, USP) PATIENT ASSISTANCE PROGRAM
PRODUCT REQUEST**

Instructions

Please complete this product request and send it to the address or fax number listed below. To receive replacement product, providers should submit this form at the end of each month. Complete one form for each patient enrolled in the Venofer® (iron sucrose injection, USP) Patient Assistance Program. This form **must** be signed by a physician.

Submit To:

Venofer® PATIENT ASSISTANCE PROGRAM
c/o InTeleCenter™
P.O. Box 4280
Gaithersburg, MD 20885-4133
Phone: 800-282-7712 Fax: 240-632-3805

Provider Information

Date submitted: _____

Physician Name: _____
 Contact Person (other than physician): _____
 Facility/Practice Name: _____
 Address (no PO boxes please): _____
 City: _____ State: _____ Zip Code: _____
 Telephone : (____) _____ FAX: (____) _____

The Venofer® Patient Assistance Program ships replacement product to the provider.

Patient Information

Patient's Name: _____ Case number: _____
 Social Security Number: _____ Phone: _____ (____) _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

Venofer® (iron sucrose injection, USP) Utilization

Medication	Lot Number(s)	Dates of Administration	Dosage per day	Please specify total number of vials used
Venofer® (iron sucrose injection, USP)				

I administered Venofer® for the above hemodialysis patient to treat iron deficiency anemia. My patient has consented to my providing you this information. Neither the patient nor any third party was charged for Venofer® provided to this patient and for which replacement product is requested. In addition, I represent that the information contained in this form is complete and accurate to the best of my knowledge and agree to notify the Program of any changes I become aware of which could affect the eligibility of this patient.

X _____

Physician's Original Signature (stamps not accepted)

_____ Date

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

Office use only:

From Covance Health Economics and Outcomes Services Inc., 800-282-7712 to ARI (____) ____ - ____ Date: _____ Case #: _____