

**AMERICAN REGENT 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 American Regent Venofer[®] Patient Assistance Program. This form **must** be signed by a physician.

Submit To:

AMERICAN REGENT VENOFER[®] PATIENT ASSISTANCE PROGRAM
c/o InTeleCenter[™], P.O. Box 4820
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 American Regent 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	Dates of Administration	Dosage per Day	Specify total number of vials used
Venofe [®] (iron sucrose injection, USP)			

I have administered Venofer[®] for the above patient to treat iron deficiency. 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. (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.

Office use only:
From Covance Market Access Services Inc., (800) 282-7712 to AR (____) ____-____ Date: _____ Case #: _____