

**VENOFER<sup>®</sup> PATIENT ASSISTANCE PROGRAM  
PRODUCT REQUEST**

**Instructions**

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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<sup>®</sup> Patient Assistance Program. This form **must** be signed by a physician.

**Submit To:**

Venofer<sup>®</sup> PATIENT ASSISTANCE PROGRAM  
c/o InTeleCenter<sup>™</sup>  
PO Box 4280  
Gaithersburg, MD 20885-4133  
Phone: 800-282-7712 Fax: 240-632-3805

**Provider Information**

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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<sup>®</sup> Patient Assistance Program ships replacement product to the provider.

**Patient Information**

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Patient's Name: \_\_\_\_\_ Case number: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Venofer<sup>®</sup> (iron sucrose injection) Utilization**

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Medication	Lot Number(s)	Dates of Administration	Dosage per day	Please specify total number of vials used
Venofer <sup>®</sup> (iron sucrose injection)				

I administered Venofer<sup>®</sup> 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<sup>®</sup> 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. AR 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 ARL (\_\_\_\_) \_\_\_\_-\_\_\_\_ Date: \_\_\_\_\_ Case #: \_\_\_\_\_