AMERICAN REGENT IV IRON
PATIENT ASSISTANCE PROGRAM
PRODUCT REQUEST FORM

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 IV Iron Patient Assistance Program. This form **must** be signed by a physician.

Submit To:
AMERICAN REGENT IV IRON
PATIENT ASSISTANCE PROGRAM
c/o InTeleCenter, P.O. Box 4280
Gaithersburg, MD 20885-4133
Phone: 877-4-IV-IRON (877-448-4766) 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: _____
Daytime Phone: _____ Fax: _____
The American Regent IV Iron Patient Assistance Program ships replacement product to the provider.

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

Product Utilization

Medication	Lot Number	Dates of Administration	Dosage per day	Specify total numbers of vials used
☐ **VENOFER®** (**iron sucrose injection, USP**)				
☐ **INJECTAFER®** **(ferric carboxymaltose injection)**				

I have administered Venofer® or Injectafer®, as indicated above, for the above 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® or Injectafer® 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, Inc., (877) 448-4766 to AR (___) ___-____ Date: _____ Case #: _____