DAIICHI SANKYO/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 #: _____

Social Security Number: _____ Sex: _____ Date of Birth: _____

Address _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Is this patient currently 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)/Daiichi Sankyo, Inc. (DSI). 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 or DSI 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.

_____ _____

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 Daiichi Sankyo, Inc. (DSI), American Regent, Inc. (AR) or an authorized DSI or 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 DSI or 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.

_____ _____

Provider Signature Date

Daiichi Sankyo, Inc. (DSI) or 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: Daiichi Sankyo/American Regent IV Iron Patient Assistance Program
c/o IV Iron Hotline, P.O. Box 220342, Charlotte, NC 28222 Phone: 877-448-4766 Fax: 888-354-4856