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

Submit To: IV IRON PATIENT ASSISTANCE PROGRAM
c/o IV Iron Hotline, P.O. Box 220342, Charlotte, NC 28222
Phone: 877-4-IV-IRON (877-448-4766) Fax: 888-354-4856

Date submitted: _____

Provider Information

Physician Name: _____

Contact Person (other than physician): _____

Facility/Practice Name: _____

Address (no PO boxes please): _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Fax: _____

The IV Iron Patient Assistance Program ships replacement product to the provider.

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

Product Utilization	Lot Number	Dates of Administration	Dosage Per Day	Specify Total Number of Vials Used
☐ **Injectafer®** (ferric carboxymaltose injection)				
☐ **Venofer®** (Iron Sucrose Injection, USP)				

I have administered Injectafer®/Venofer® 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 Injectafer®/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

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. DSI or AR also reserves the right to make an independent determination of medical indigence in all cases.

Office use only:

From IV Iron Hotline (877) 448-4766 to AR ( ) - Date: _____ Case #: _____