Daiichi-Sankyo | AMERICAN REGENT™

IV Iron Patient Assistance Program

PRODUCT REQUEST FORM

INSTRUCTIONS

- Complete one form for each patient
- Complete all required fields
- Print the form
- Obtain physician signature
- Fax the completed form to 888-354-4856

Timing Notice
Submit this form **by the end of the day on Wednesday** in order for the product to be shipped overnight the following Wednesday (holidays and weather may cause delays).

PLEASE SEND THIS FORM TO:

Daiichi Sankyo/American Regent
IV Iron Patient Assistance Program
c/o IV Iron Hotline
PO Box 220342
Charlotte, NC 28222
Phone: 877.448.4766 \\ Fax: 888-354-4856

IV Iron Patient Assistance Program

877-4-IV-IRON
(877-448-4766)

Program staff are available Monday through Friday, between 9 am and 8 pm ET.

PROVIDER INFORMATION

Facility/Practice Name: **Physician Name:**

Office Contact: **Phone:** **Fax:**

Shipping Address (where you prefer your replacement product to be sent)**:**

City: **State:** **Zip:** *The IV Iron Patient Assistance Program ships replacement product to the provider.*

PATIENT INFORMATION

Patient Name: **Case Number:** **Date of Birth:**

Address (No PO Boxes Please: **City:** **State:** **Zip:**

PRODUCT UTILIZATION

☐ **Venofer®** (iron sucrose injection, USP)

Lot number: Dates of Administration: Dose Administered: Total Number of Vials Used:

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I have adminstered 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 Venofer provided to this patient and for which replacement product is being 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.

Physician Signature: **Date:**

☐ **Injectafer®** (ferric carboxymaltose injection)

Lot number: Dates of Administration: Dose Administered: Total Number of Vials Used:

Lot number: Dates of Administration: Dose Administered: Total Number of Vials Used:

I have adminstered 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 Injectafer provided to this patient and for which replacement product is being 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.

Physician Signature: **Date:**

American Regent/Daiichi Sankyo reserve the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. American Regent/Daiichi Sankyo also reserve the right to make an independent determination of medical indigence in all cases.