



Fresenius Medical Care

Phoslyra[®] Patient Assistance Program

Fax Completed Form to: 866-496-8638

Program Phone Number: 877-774-6756

For 2012 Applications Only

Patient Demographic Information		
Patient Name: _____ First Last		Social Security Number: _____ -- _____ -- _____
Street Address: _____		DOB: _____ MM/DD/YY
City _____ State _____ ZIP _____	Home phone (or best number to contact if needed): _____	
Allergies: Circle those that apply, or write in: <input type="radio"/> None <input type="radio"/> Aspirin <input type="radio"/> Codeine <input type="radio"/> Sulfa <input type="radio"/> Other	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Select for Spanish Speaking Patient
Are you a citizen or permanent resident of the United States? Yes <input type="checkbox"/> No <input type="checkbox"/> (Please submit proof of permanent residency, if applicable)		
Optional Questions: Responses Do Not affect Program Eligibility:		
Patient's Previous Phosphate Binder Therapy: <input type="checkbox"/> PhosLo Gelscaps <input type="checkbox"/> Renagel [®] <input type="checkbox"/> Fosrenol [®] <input type="checkbox"/> Tums [®] <input type="checkbox"/> Calcium Carbonate <input type="checkbox"/> Other: _____		
If you are in the Medicare "Coverage Gap", in what month did you enter the Coverage Gap? _____		

Financial Information - Be sure to attach proof of income

Number of adults in household (including yourself): _____	MONTHLY	OR	YEARLY
Patient's Wages	\$ _____		\$ _____
Spouse's Wages	\$ _____		\$ _____
Other/Additional Household Income			
Pension/Retirement	\$ _____		\$ _____
Unemployment	\$ _____		\$ _____
Social Security (all types)	\$ _____		\$ _____
Veteran's Benefits	\$ _____		\$ _____
Other (child support/alimony/aid to dependent)	\$ _____		\$ _____
Total Income	\$ _____		\$ _____
Total household income spent on outpatient prescription drugs in 2012 (excluding premiums)	\$ _____		\$ _____

Patient Diagnosis

Do you have Medicaid Prescription Drug Coverage at this time? Yes No
If not and you have been denied, please attach a copy of the Medicaid Denial Letter.

Have you applied for the Low Income Subsidy? Yes No Pending
If not eligible, reason for denial: _____

Have you applied to enroll in a State Pharmacy Assistance Program? Yes No
If not eligible, reason for denial: _____

Patient Name: _____

DOB: _____

Prescriber Information and Shipping Address (all fields are required for consideration)

Patient's Home Address: (No PO Boxes please) _____

Phone: _____

City: _____

State: _____

Zip Code: _____

Facility Name: _____

Facility Address: _____

City: _____

State: _____

Zip Code: _____

Facility Contact Name: _____

Contact Number: _____

Fax Number: _____

Prescriber

Full Name/Title: _____

State License #: _____

Required by law

Patient DiagnosisHas the patient been diagnosed with ESRD (End Stage Renal Disease 585.6) AND on Dialysis? Yes No**Phoslyra Prescription Information (all fields are required for consideration)**Prescribed Drug: Phoslyra calcium acetate oral solution
667 mg per 5 mLDirections: Take 1tsp 2tsp OR 1 tbsp 2 tbsp by
mouth with each meal. Additional Instructions _____**Other Instructions:**Dispense a **60-day** supply with each fill, and we only
dispense full bottle. Do Not Substitute (Dispense as written)**Authorized Refills (Max of 2 refills):** One refill Two refills**PRESCRIBER AGREEMENT AUTHORIZATION**

My signature below certifies that the person named on this form is my patient, and I will be supervising this patient's treatment. I also certify that any medications received from Fresenius Medical Care North America under the Phoslyra PAP are medically necessary for the patient named on this form, and will be used only by that patient. These medications will not be offered for sale, trade, or barter. In addition, I certify that no claim for reimbursement for any medications furnished under the Phoslyra PAP will be submitted to the Medicare program, any state Medicaid program, any other health care benefit plan, payor or patient, or returned for credit. I agree to return or dispose of any undispensed Phoslyra PAP product in accordance with the instructions of RxCrossroads. **To the best of my knowledge, this patient has no prescription drug coverage other than a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug plan (MA-PD).**

Prescriber Signature_____
Date**PATIENT AGREEMENT AND AUTHORIZATION**

I authorize my prescriber to furnish specific information about my medical condition and financial situation to Fresenius Medical Care North America and its contractor, RxCrossroads, solely for purposes of administering and determining my eligibility to participate in the Phoslyra Patient Assistance Program (the "PAP"). For example, my information, including the fact of my participation in the PAP may be shared with physicians and health plans or the Centers for Medicare and Medicaid ("CMS") in order to provide PAP services and coordinate benefits or share information as required. I further authorize RxCrossroads to share de-identified information obtained hereunder with Fresenius Medical Care North America for market research purposes. My personal information will not be released in an identifying form to a third party without my personal authorization, except as discussed herein or required by law. I understand that once my health information is released to Fresenius Medical Care North America, it may not be protected by federal health privacy laws. I may revoke this authorization at any time in writing, but this shall not affect any action taken by Fresenius Medical Care North America or RxCrossroads in reliance on this authorization before it received my written notice of revocation. By signing below, I certify that the information I have provided on this Phoslyra PAP enrollment form is true, complete and correct and that I agree to abide by the rules, procedures and conditions of the PAP. I also certify that I have no other nor am I eligible for any governmental or private health insurance coverage (except for a PDP or a MA - PDP) for prescription drugs including but not limited to Medicaid, employer/retiree-sponsored coverage, a state pharmacy assistance program (SPAP), or a State Kidney/Renal Disease Program, and that I will not request any payment from any third party, including my Medicare Prescription Drug Plan or a Medicare Advantage Prescription Drug plan for any drugs furnished to me under this PAP. I understand that any medications received under the PAP are for my own use and not for distribution to any third party. I understand that Fresenius Medical Care North America sets the criteria for the PAP and that neither completion of this application nor acceptance into the PAP now, or at any time, is a guarantee that I am entitled to or will continue to participate in or receive assistance through the PAP. By signing below, I agree that Fresenius Medical Care North America or RxCrossroads may contact me directly to obtain additional information to determine or confirm my eligibility, and to audit any information provided herein. I understand that Fresenius Medical Care North America reserves the right to discontinue or modify the PAP at any time without prior notice. **I UNDERSTAND THAT IF I AM ENROLLED IN A PDP OR A MA-PDP, I MAY NOT APPLY ANY ASSISTANCE RECEIVED HEREUNDER TOWARD MY "TRUE OUT OF POCKET" ("TROOP") EXPENDITURES,** and that it is my responsibility to notify my PDP or MA-PD of my enrollment in the PAP. I understand that my prescribing physician is responsible for choosing which prescription products are right for me. FRESENIUS MEDICAL CARE NORTH AMERICA IS NOT RESPONSIBLE FOR VERIFYING MY MEDICAL CONDITION OR MY PRESCRIBER'S SELECTION OF PRODUCTS. I agree that all information I have provided here or in any other form is accurate and complete. **I agree to notify RxCrossroads at 877-774-6756 if any of this information, my employment status, or my financial need changes. I understand that any misrepresentation, or submission of false information, or exclusion of material information may require me to pay for any patient assistance for which I was not actually qualified, and may be grounds for legal action against me.**

Patient Signature (or signature of Patient's duly authorized representative)_____
Date

If authorized representative: Relationship to Patient: _____

Patient Name: _____

DOB: _____

Insurance Information

**Medicare claim number
(If enrolled)**

**Medicare effective date
(If enrolled)**

Do you currently have any form of prescription drug coverage? Yes No

Please check below

- Employer furnished or private drug coverage
- VA or Military Benefits
- Medicaid
- Medicare Part B (covers some medications)
- Medicare Part D
(Medicare Prescription Drug Plan PDP or Medicare Advantage Prescription Drug Plan MA-PD)
- State assistance program for medicines _____
- Other _____

Please list

Insurance Carrier _____

Insurance Carrier _____

Policy Holder's Name _____

Policy Holder's Name _____

Group / plan number _____

Group / plan number _____

Patient Name: _____

DOB: _____

Before you mail this application (incomplete applications will not be considered):**To assist us in processing your application, please be sure you have done the following:****Have you attached:**

- Proof of permanent residency, if applicable?
- Proof of income?

2011 Federal Income Tax Returns for yourself, your spouse, and dependents, if you filed. We may Request updated proof of income from all sources outside of your Income Tax Return.

And/or

If you did not file a 2011 Federal Income Tax Return, please attach your 2011 (W2's or SSA1099's) OR Social Security Income Yearly Benefits Statement

And/or

Most recent pay stubs

If Applicable, please provide

- Medicaid Eligibility Denial Letter (if applicable)?
- Social Security Benefit Award Letter?
- Copies of any insurance cards?

If you have a Medicare Part D Prescription Drug Plan, please provide

- Copies of a 2012 history printout from your pharmacy?

Have you signed the application? If the application has been signed by someone other than the patient, please submit a copy of the Power of Attorney.

Has your physician signed the prescriber agreement? The physician that prescribes the Phoslyra is the physician that has to sign the application.

*** All applications are valid six-months from prescriber's signature date or until December 31st of each year, whichever comes first. ***

Fax completed application to: (866)496-8638

Or

Mail completed application with income documentation to:

**Fresenius Phoslyra PAP
c/o RxCrossroads
10350 Ormsby Park Place Suite #500
Louisville, Kentucky 40223**