

Patient Name _____

IF PATIENT IS ENROLLED IN A MEDICARE PART D PLAN DO NOT FILL IN THIS SIDE FOR ASSISTANCE
IF PATIENT IS A MEDICARE PART D SUBSCRIBER PLEASE CONTACT RENASSIST

Has the patient previously applied to Renal Patient Assistance Program (RPAP)? Yes No Date: _____

For MD Offices Only: Does the patient wish to be contacted directly with Verification/Assistance Result? Yes No

Complete information on all household members is required. Do not leave any fields blank; use a zero or dash wherever applicable. <u>Incomplete applications will not be considered.</u>		Monthly Household Expenses	
		Rent	\$
		Mortgage	\$
		Food	\$
		Telephone	\$
		Utilities (electric/gas/water)	\$
		Car Payment	\$
		Gasoline/Taxi/Bus	\$
		Credit cards	\$
		Loans	\$
		Other (Specify)	\$
Assets		Monthly Medical Expenses	
Checking Account(s)	\$	Patient's Medication	\$
Savings Account(s)	\$	Family Members' Medications	\$
Stocks/Bonds	\$	Monthly Insurance Expenses	
Total Current Assets*	\$	Health Ins. (include Dental)	\$
Total Number of Household Members	#	Life Insurance	\$
Monthly Income		Car Insurance	\$
Patient's Monthly Take-Home Pay	\$	Other Insurance	\$
Spouse's Monthly Take-Home Pay	\$	Total Monthly Expenses	\$
Additional Income			
Social Security	\$		
Aid to Dependent Children	\$		
Retirement Income	\$		
Veteran's Benefits	\$		
Other (IRA, Annuity, please specify)	\$		
Total Monthly Income**	\$		

*Do NOT include Total Current Assets in Total Monthly Income

**Total of Monthly Income and Additional Income (excluding Total Current Assets).

Attestation/Release of Information

I have reviewed the applicant's financial information on this form.

Healthcare Professional Signature: _____ **Date:** _____

Genzyme's Renal Reimbursement Helpline ("Helpline") must have the patient's authorization to conduct insurance research. By providing authorization, the patient permits the Helpline and/or its affiliates to contact the insurer(s) and allows the insurer(s) to disclose the relevant information to the Helpline. Helpline may need to provide to insurer(s) the patient's name, date of birth, Social Security number, diagnosis, insurance information, or other information. The dialysis unit may already have the patient's written consent to use his or her personal data for its reimbursement processing; however, the dialysis unit may need to obtain written authorization, in accordance with applicable state and federal regulations, to release that information to the Helpline and to allow for the patient's insurer(s) to disclose information to the Helpline. By signing this document, I attest that the financial information I have provided is complete and accurate and I agree that the Fund may verify this information. I also agree that the Fund may disclose information contained in the application to my dialysis caregivers and/or its pharmacy vendors and the Genzyme Renal Reimbursement Helpline.

Patient's Signature: _____ **Date:** _____

Please return this completed form by Fax OR email
 Contact Renassist directly for mailing information:

Phone: 1-800-847-0069 Fax: 877-363-6732 Email: PAP@genzyme.com

PRESCRIPTION SUBMISSION FOR RENVELA® (sevelamer carbonate) TABLETS

_____ Prescribing Physician Full Name		_____ Specialty
_____ Facility Name		
_____ Address		
_____ City	_____ State	_____ Zip
() _____ Phone	() _____ Fax	
_____ Patient Name		
_____/_____/_____ Patient Date of Birth		
_____ Patient Address		
_____ City	_____ State	_____ Zip
<u>Rx:</u>		
Renvela 800mg Tablets		
_____ # tablets po; TID with MEALS;		
_____ # tablets po; QD with SNACK(S).		
Alternative Sig:		

Dispense up to a 4-month supply.		
Dispense # _____		

_____ Physician Signature		_____ Date
_____ DEA# (Required)		_____ Professional Designation

PRESCRIPTION SUBMISSION FOR HECTOROL® (doxercalciferol capsules and injection)

Prescribing Physician Full Name		Specialty
Facility Name		
Address		
City	State	Zip
() _____	() _____	_____
Phone	Fax	
Patient Name		
_____/_____/_____		
Patient Date of Birth		
Patient Address		
City	State	Zip
Rx:		
Hectorol Capsules: 0.5mcg <input type="checkbox"/>	1mcg <input type="checkbox"/>	2.5mcg <input type="checkbox"/>
↑	CHECK ↑	ONE ↑
Sig: _____ Capsules po; (QD <input type="checkbox"/>) (TIW <input type="checkbox"/>)		
↑	CHECK ONE ↑	
Alternative Sig:		
Dispense up to a 4 months supply. Dispense # _____		
Hectorol Injection: 4 mcg/ 2 mL		
Sig: _____ mcg Injection TIW		
Dispense up to a 4-month supply. Dispense # Vials _____		
Physician Signature		Date
DEA# (Required)	Professional Designation	

Renassist Insurance Verification Request & Genzyme's Renal Patient Assistance Program (RPAP)

CHECKLIST

This application is for Renassist Insurance Verification Requests and Genzyme Renal Patient Assistance Program (RPAP) ONLY. If the patient is enrolled into a Medicare Part D plan, please do NOT submit this application. Please call Renassist for information on the Renvela Medicare Part D Assistance Program.

1-800-847-0069

To expedite processing, please check off that the following have been completed before submitting the application:

For ALL Requests:

- Required application fields have been completed
- Patient Health Insurance Information is fully completed
- Healthcare Professional has checked off and signed Attestation
- Applicant has signed Release of Information Authorization

For Renassist Insurance Verification Requests:

- Copies of the Front and Back of Insurance Card(s) including Medicare, are attached

For Renal Patient Assistance Program (RPAP) NON PART D ASSISTANCE:

- Applicant is **NOT** enrolled in a Medicare Part D (PDP) or Medicare Advantage Plan (MA-PD)
 - If they are enrolled, contact Renassist for the Renvela Medicare Part D Assistance Program application
- Applicant has NOT been accepted for LIS through Social Security
- If the applicant's income is $\leq 150\%$ of FPL
 - SSA LIS Official "Notice of Denial" letter is attached
- If the applicant's income is $\geq 150\%$ of FPL but have been denied LIS
 - SSA LIS Official "Notice of Denial" letter is attached
- All reported income is in **NET** (not Gross) numbers
 - a. All income is after taxes and other deductions
- Prescription
 - All fields are completed
 - Prescription is signed by prescribing Healthcare Provider
 - DEA number is required

**Pharmacy Provider will ship up to a 4 month supply of free drug.
Patients can re-apply at the end of each 4 month supply.**