

**Venofer® (iron sucrose injection, USP)
PATIENT ASSISTANCE PROGRAM PATIENT APPLICATION**

Please send this completed form to: **Venofer® Patient Assistance Program, c/o RxCrossroads**

PO Box 18370, Louisville, KY 40261

Phone: 1-877-MYIRON1 (1-877-694-7661) Fax: 1-866-496-8638

Patient Information

Case Number: [Case ID] _____ (RxCrossroads use)

Patient Name: _____ US Citizen _____ Legal Entrant _____ Other _____
 Social Security Number: _____ Sex: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Daytime Phone : (____) _____ Evening Phone: (____) _____

Provider Information

Physician Name: _____
 Contact Person (other than physician): _____
 Facility/Practice Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone : (____) _____ Fax: (____) _____

Insurance Information

Please provide data on insurers, programs, or other sources that provide prescription drug benefits to this patient:

Insurer	Status (circle one)	Plan Name	Effective Date
<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Pending	_____ / ____ / ____
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Pending	_____ / ____ / ____
<input type="checkbox"/> Commercial	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Pending	_____ / ____ / ____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Pending	_____ / ____ / ____
<input type="checkbox"/> Patient does not have and is currently unable to obtain any insurance coverage or program benefit that includes prescription drugs.			

Financial Information

Total annual household income (from most recent federal tax return): \$ _____ (Proof of income required)

Patient Certification and Consent

- I would like to receive Venofer® (iron sucrose injection, USP) free of charge from Fresenius Medical Care North America. 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 Fresenius Medical Care North America removes my name and any other identifying information.
- I understand that Fresenius Medical Care North America 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® may be given to me without cost now, this does not mean I will be entitled to receive it without cost indefinitely.
- I agree that all information I have provided here or in any other information reported to the Venofer Patient Assistance Program is accurate and complete.
- I agree to notify RxCrossroads at 877-694-7661 if any of this information, my employment status, or my financial need changes. I understand that any misrepresentation, 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

Date

Patient Name

Date of Birth:

Provider Certification Statement

- I have determined that Venofer® 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 Fresenius Medical Care North America or an authorized Fresenius 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 Fresenius Medical Care North America 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® for which replacement product is sought under this Program.
- I hereby certify that I/we have complied with the final federal rules under the Health Insurance Portability and Accountability Act (HIPAA) governing the privacy, security and use of protected health information, as applicable, in administering this request, and that all patient consents so comply.
- 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.

Physician Signature

Date

Fresenius Medical Care North America reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. Fresenius Medical Care North America and its contractor, RxCrossroads, reserves the right to make an independent determination of medical indigence in all cases.