



Fresenius Medical Care

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

Please send this completed form to: Venofor® 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: (Rx Crossroad use)

Patient Name: 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:

Table with 4 columns: Insurer, Status (circle one), Plan Name, Effective Date. Rows include Medicare Part B, Medicaid, Commercial, Other, and Patient does not have and is currently unable to obtain any insurance coverage...

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 Venofor® (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 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.

Signature

Date

Provider Certification Statement

- I have determined that Venofor® 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 Venofor® 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.

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.