Phoslyra®

Fresenius Medical Care

Phoslyra® Patient Assistance Program

Phone: 1-877-774-6756

FACSIMILE TRANSMITTAL

Date:	[Today's Date]		
To:	[Contact Person]	**Phone:** **Fax:**	
From:	[Reimbursement Specialist]	**Phone:** **Fax:**	(877)-774-6756 (866)-496-8638
RE:	Patient Assistance Application		
Number of Pages (including cover sheet):			5

Message: **<u>Revised Unified Phoslyra 2014 Application.</u>** This application applies to patients who have no drug coverage or patients who have Medicare Part D only. The application can be submitted by the facility or the patient. If you have any questions regarding this application, please call 877-774-6756.

The following Criteria Apply:

You must be diagnosed with ESRD (End-Stage-Renal Disease ICD-9 code of **585.6**) and be on Dialysis.

You must submit proof of income if applicable.

Please call if you do not receive all pages.

Fresenius Medical Care

Phoslyra® Patient Assistance Program

Fax Completed Form to: 866-496-8638
Program Phone Number: 877-774-6756

For 2014 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:
○ None ○ Aspirin ○ Codeine ○ Sulfa ○ Other

Gender: ☐ Male ☐ Female

☐ Select for Spanish Speaking Patient

Are you a citizen or permanent resident of the United States? Yes ☐ No ☐
(Please submit proof of permanent residency, if applicable)

Optional Questions: **Responses *Do Not affect Program Eligibility*:**

Patient's Previous Phosphate Binder Therapy:
☐ PhosLo Gelcaps ☐ Renagel® ☐ Fosrenol® ☐ Tums® ☐ Calcium Carbonate ☐ 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 2014 (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:**
Dialysis Facility Name Only:	**Dialysis Facility Address Only**: **City:** **State:** **Zip Code:**	
Dialysis Facility Contact Name Only:	**Dialysis Contact Number Only:**	**Dialysis Fax Number Only:**
Prescriber Full Name/Title:_____	**State License # Only:** _____ Required by law	

Patient Diagnosis

Has the patient been diagnosed with ESRD (End Stage Renal Disease- ICD-9 code of 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 mL	**Directions:** 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)**

What was your Zip Code at the time you applied for Medicare? _____

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

Please check below all that applies:

- ☐ 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 all that are indicated above:

Insurance Carrier _____ Insurance Carrier _____

Policy Holder's Name_____ Policy Holder's Name_____

Group / plan number _____ Group / plan number _____

Insurance Carrier _____ Insurance Carrier _____

Policy Holder's Name _____ Policy Holder's Name _____

Group / plan number _____ Group / plan number _____

********** PLEASE SUBMIT COPIES OF ANY INSURANCE CARDS ***********

Patient Name: _____ **DOB:** _____

Before you fax or 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? (Green Card)

☐ Proof of income?

2013 Federal Income Tax Returns for yourself, your spouse, and dependents. **We may request Updated income outside of the 2013 Federal Income Tax Return.**

OR

If you did not file your 2013 Federal Income Tax Return, please provide 2014 proof of income from all sources.

If Applicable, please provide

☐ Medicaid Eligibility Denial Letter
☐ Social Security Benefit Award Letter for 2014
☐ Copies of any insurance cards

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

☐ Copies of a 2014 history printout from your pharmacy or your Medicare Part D Plan

☐ **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 for six-months from the prescriber's signature date or until December 31st of each year. Whichever comes first.

PLEASE MAKE A COPY OF THE APPLICATION FOR YOUR RECORDS

Fax completed application to: (866)496-8638

Or

Mail completed application along with income documentation and copies of insurance cards to:

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