VELPHORO®
(sucroferric oxyhydroxide)
chewable tablets

Patient Assistance Program

Fax Completed Form to: 1-866-496-8638
Program Phone Number: 1-877-774-6756

Phoslyra®
calcium acetate oral solution
667mg per 5 mL

Patient Demographic/Shipping Information

Patient First Name:	**Patient Last Name:**		**SSN**:
Street Address: *(NO P.O. BOXES)*			**DOB:**
City:	**State:**	**Zip:**	**Phone:**
Are you a citizen or permanent resident of the United States? ☐ **Yes** ☐ **No**	**Are you currently on dialysis?** ☐ **Yes** ☐ **No**		**Gender:** ☐ Male ☐ Female

Patient Insurance Information

Do you have insurance? ☐ **Yes** ☐ **No**	**If 'Yes' please select insurance type:** ☐ Commercial ☐ Medicare Part: _____ ☐ Medicaid ☐ VA/Military Benefits ☐ Other: _____
Primary Payer Name:	**Member ID Number:**
Policy Holder Name:	**Group Number: BIN**

Medicaid Information

Are you enrolled in Medicaid? ð **Yes** ð **No** **Medicaid ID number** _____

If you are enrolled in Medicaid, is your coverage for Emergency Only ð **Yes** ð **No**

Do you have Medicaid Prescription Drug Coverage at this time? o **Yes** o **No**

If you were denied Medicaid Prescription Drug Coverage, please include a copy of the Medicaid Denial Letter with this application.

Have you been denied Medicaid? ð **Yes** ð **No** ***If you have been denied Medicaid, please include a copy of the Medicaid denial letter with this application.***

Medicare Information

Are you enrolled in Medicare? ð **Yes** ð **No** **Medicare ID number** _____

If you are enrolled in Medicare, are you in a 90-day waiting period for Medicare Coverage? ð **Yes** ð **No**

Are you enrolled in Medicare Part D? ð **Yes** ð **No** ð **I Have Applied but My Application Is Pending**

If you are enrolled in Medicare Part D, on what date did you enter the donut hole? (date)_____

Other Financial Assistance Programs

Have you applied for Low Income Subsidy? o **Yes** o **No** o **I Have Applied but My Application is Pending**

If you applied for a Low Income Subsidy but were told you were not eligible, what was the reason for the denial? _____

Are you eligible for other federal, state, or local government programs (VA/DOD/IHS)? ð **Yes** ð **No**

If you are eligible for such other programs, please identify all programs for which you are eligible.

☐ ***Please attach a copy of the patient's insurance cards***
(Front and back copy of primary, secondary, tertiary, supplemental and/or pharmacy cards, if applicable)

Financial Information

Number of related adults in household (including patient):	**MONTHLY**	**ANNUAL**
Patient's Wages	$	$
Spouse's Wages	$	$
Other/Additional Household Income	$	$
Pension/Retirement	$	$
Unemployment	$	$
Social Security (all types)	$	$
Veteran's Benefits	$	$
TOTAL INCOME	$	$

☐ ***Please attach a copy of current or previous year income documentation***
(i.e. W2's, tax statements, pay stubs, government income documentation, pension, social worker 'no income' letter)

FRESENIUS MEDICAL CARE
RENAL PHARMACEUTICALS

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 Velphoro Chewable Tablets and 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. 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 Velphoro Chewable Tablets Patient Assistance Program and Phoslyra Patient Assistance Program enrollment form is true, complete and correct and that I agree to abide by the rules, procedures and conditions of the Patient Assistance Program. 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 Patient Assistance Program. I understand that any medications received under the Patient Assistance Program 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 Patient Assistance Program and that neither completion of this application nor acceptance into the Patient Assistance Program now, or at any time, is a guarantee that I am entitled to or will continue to participate in or receive assistance through the Patient Assistance Program. 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 Patient Assistance Program at any time without prior notice.

I UNDERSTAND THAT IF I AM ENROLLED IN A PDP OR AN 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 Patient Assistance Program**.** 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 authorization representative)* Date

If authorized representative, relationship to patient: _____

Patient First Name:	**Patient Last Name:**	**DOB:**

Prescriber Information			
Prescriber First Name:	**Prescriber Last Name:**		
Practice Address:			
City:	**State:**	**Zip:**	
MD Office Contact Name:	**Phone:**	**Fax:**	
State License #:	**NPI #:**	**DEA #:**	
Dialysis Facility Contact Name:	**Phone:**	**Fax:**	**Email:**

Prescription Information (Patient must be on Dialysis)		
Select Medication:	☐ Phoslyra® (calcium acetate oral solution 667 mg per 5 mL)	☐ Velphoro® Chewable Tablets (sucroferric oxyhydroxide 90 tab)
Dosing:	Dispense a **60-day** supply with each fill	Dispense **30-day** supply with each fill
Directions:	Take ☐ 1tsp ☐ 2tsp **OR** ☐ 1 tbsp ☐ 2 tbsp by mouth with each meal Additional Instructions:	Take one tablet by mouth with each meal. Tablets may be crushed. Additional Instructions:
Authorized Refills:	☐ _____ (max of two refills)	☐ _____
☐ Dispense as written/no substitutions		☐ Substitution permitted

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 Velphoro Chewable Tablets and Phoslyra Patient Assistance Program 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 Velphoro Chewable Tablets Patient Assistance Program and Phoslyra Patient Assistance Program will be submitted to the Medicare program, any state Medicaid program, any other health care benefit plan, payer or patient, or returned for credit. **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*

All applications are valid for six-months from the prescriber's signature date or until December 31st, whichever comes first.

Please make a copy of this application for your records

Velphoro is a registered trademark of Vifor Fresenius Medical Care Renal Pharma Ltd.
Distributed by: Fresenius Medical Care North America, Waltham MA 02451
Phoslyra is a registered trademark of Fresenius Medical Care Holdings Inc.
 PN 102729-13 Rev. A 01/2015

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RENAL PHARMACEUTICALS