AR Assist Patient Assistance Program

PATIENT ENROLLMENT FORM

HOW TO USE THIS FORM

- Complete all required fields
- Print the form
- Obtain physician and patient signatures on page 1
- Fax it to 888-354-4856

Upon receiving the form, American Regent® will assess patient eligibility for product support programs and conduct a benefits verification, if requested.

PLEASE SEND THIS FORM TO:

American Regent
AR Assist Patient Assistance
PO Box 500227
San Diego, CA 92150
Phone: 877-448-4766 \\ Fax: 888-354-4856

AR Assist Patient Assistance

877-448-4766

Program staff are available Monday through Friday, between 8 am and 7 pm ET.

What product are you requesting assistance for: ☐ Venofer® (iron sucrose) injection, USP

Which programs does your patient need assistance with? Select all that apply.

☐ Benefits verifications ☐ Prior authorization support ☐ Claims appeal ☐ Patient Assistance Program

PATIENT INFORMATION

Full name: Date of birth: Sex: ☐ Male ☐ Female

Phone: Phone type: ☐ Home ☐ Mobile ☐ Work Email:

Address: City: State: Zip:

Primary diagnosis code (ICD-10-CM): Secondary diagnosis code (ICD-10-CM):

Household income: Household size: Permission to contact patient? ☐ Yes ☐ No

Best time to contact patient? ☐ Morning ☐ Afternoon ☐ Evening

PATIENT INSURANCE INFORMATION

Please provide information about insurers that provide health insurance benefits to this patient.

☐ Uninsured Insurance type: ☐ Commercial/Private ☐ Medicare ☐ Medicaid ☐ Medicare Advantage ☐ Veterans Affairs (VA)

HEALTH PLAN INFORMATION

Plan name:

Plan phone number:

Beneficiary name:

Policy ID: Group no.:

SECONDARY INSURANCE INFORMATION (optional)

Plan name:

Plan phone number:

Beneficiary name:

Policy ID: Group no.:

HEALTHCARE PROVIDER INFORMATION

Physician Name: Practice Name: UPIN/NPI:

Setting of care: Office Contact: Phone: Fax: Email:

Address: City: State: Zip:

PHYSICIAN ATTESTATION

I confirm that I have read and understood the Physician Attestation on page 2 of this form and agree to the terms provided therein.

Physician Signature: Date:

PATIENT CONSENT

I confirm that I have read and understood the Patient Consent on page 3 of this form and agree to the terms explained therein.

Patient Signature: Date:

For Representatives: If a representative for the patient needs to sign this form, please indicate the representative's authority to sign on behalf of the patient (eg., healthcare power of attorney, healthcare proxy, court-appointed legal guardian). Healthcare office staff cannot sign on behalf of the patient.

Representative Name:

Reason for Authority:

Representative Attestation: I confirm that I have the legal right to sign this form (as stated above) on behalf of the patient. I confirm that I have read and understood the Patient Consent on page 3 of this form and agree to the terms explained herein.

Permission to contact representative? ☐ Yes ☐ No

Representative Signature: Date:

PHYSICIAN ATTESTATION

By providing my signature on page 1 of this form, I attest that I am the prescribing healthcare provider and have determined that prescribing Venofer® (iron sucrose injection, USP) is medically appropriate, and have explained the reasons for doing so to my patient. I also agree to submit requests to the AR Assist™ Patient Assistance Program on behalf of my patient so that eligibility can be assessed.

I certify that I have received the necessary consent from my patient to release the information referenced above and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to American Regent and/or its service providers. The patient has confirmed his or her consent by reading page 3 of this form and providing his or her signature on page 1 of this form.

I agree to notify American Regent or its authorized service providers if I become aware at any time of changes in my patient's circumstances that would affect his or her eligibility for any American Regent program, including, but not limited to, changes in health insurance status or coverage, financial status, residency status in the United States, or the indication for which Venofer has been prescribed for my patient.

I understand that American Regent, Inc. reserves the right to change or terminate the AR Assist Patient Assistance Program at any time or to refuse to provide Venofer to any patient under the AR Assist Patient Assistance Program.

If my patient obtains Venofer via the AR Assist Patient Assistance Program, I attest that I understand the following:

- No free product should be sold, traded, or distributed for sale
- Participation in the AR Assist Patient Assistance Program is not contingent upon any promise for future purchase or prescribing of American Regent products

By signing page 1 of this form, I certify that a copy of the Patient Consent has been given to the patient named on page 1 or his or her representative.

PATIENT CONSENT

Release of Personal Information

By providing my signature on page 1 of this form, I authorize my physician(s), healthcare provider(s), and health insurance company to disclose my Personal Health Information (PHI); (for example, my name, address, and insurance policy number) and my medical condition (for example, my diagnosis and medications including lot numbers, administration dates, and doses) to American Regent, Inc., and its third-party vendors, suppliers, and other authorized service providers supporting the AR Assist™ Patient Assistance Program (herein described collectively as "Service Providers"). I authorize Service Providers supporting the AR Assist Patient Assistance Program to share information about me with each other. I recognize that this type of Personally Identifiable Information (PII) could include spoken or written facts about my health or healthcare, or copies of records about my health and insurance benefits provided by my healthcare provider(s) or health plan. I agree to allow Patient Assistance Program representatives to contact me via mail, telephone, or email to carry out these services. My decision to sign this form (or not to sign this form) will not affect the treatment I receive from any healthcare professional or entity involved in my care or coverage.

Use of Personal Information

I understand that the Service Providers could use or provide my information in one or more of the following ways:

- Assess my eligibility and assist with my enrollment in the AR Assist Patient Assistance Program, and contact me (and/or my legal representative) about my eligibility and enrollment status
- Verify, investigate, and help coordinate my coverage for Venofer with my health insurance company
- Assist with analyses of the efficiencies and performance of the services provided by Service Providers
- Provide me (and/or my legal representative) with educational materials, information, and support relating to American Regent services

In some instances, the Service Providers may de-identify my information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my information private; however, I understand that once my information has been disclosed to the Service Providers, how the Service Providers further disclose my information may no longer be protected under federal and state privacy laws. I understand that the AR Assist Patient Assistance Program is a component of American Regent, Inc. and that the Service Providers may be compensated by American Regent, Inc.

Consent Terms

This consent will last for 3 years from the date on this form or until I am no longer receiving Venofer or enrolled in AR Assist Patient Assistance Program services. I recognize that I do not have to sign the consent on page 1, but if I do not, I will not be able to have my insurance coverage verified, be given referrals for alternative funding sources, or have access to other services provided by or on behalf of the AR Assist Patient Assistance Program. My decision to sign this form will not affect the treatment I receive from any healthcare professional or entity involved in my care or coverage. I may cancel this consent at any time by contacting the program at 877-448-4766. By doing so, I revoke my consent for my healthcare provider to disclose my health information to American Regent, Inc., or its service providers, as well as discontinue my participation in the support program. I recognize that revoking my consent will not affect the use or the disclosure of health information that was already disclosed before my cancellation.

I confirm that I have received a copy of this consent, and I know I have a right to see or copy the information my healthcare providers or payers have given to the service providers.

Additional Information to Assess Eligibility for the AR Assist Patient Assistance Program

I agree to allow American Regent, Inc. and its associated service providers to use my demographic information including, but not limited to, my name, date of birth, and/or address as needed to access my credit information and information derived from public and other sources. This includes information from a consumer reporting agency (credit bureau) to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the AR Assist Patient Assistance Program. American Regent, Inc. and its associated service providers reserve the right to request additional documents and information at any time. I agree to notify my healthcare providers if I undergo any changes that would, to my knowledge, affect my eligibility including, but not limited to, changes in health insurance status or coverage, financial status, and my residing status in the United States.

The terms of this document are governed by and interpreted in accordance with the laws of the state of New York, without regard to the principles of conflict of laws and any applicable federal laws.