AMERICAN REGENT® | AR Assist® | injectafer® ferric carboxymaltose injection

INJECTAFER PATIENT ENROLLMENT FORM

PLEASE SUBMIT THIS FORM PRIOR TO INJECTAFER ADMINISTRATION

- Complete all required fields
- Print the form
- Obtain physician and patient signatures on page 1
- Fax it to 1-833-471-9988
- Give patient a copy of the Patient Consent on page 3

Upon receiving the form, AR Assist will be able to assess patient eligibility for Injectafer support programs as well as conduct a benefits verification if requested.

1-877-448-4766

www.AR-assist.com

Fax: 833-471-9988

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

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

1 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):** ______

Permission to contact patient? ☐ Yes ☐ No **Best time to contact patient?** ☐ Morning ☐ Afternoon ☐ Evening

Expected Date of Infusion: __ / __ / ____

2 PATIENT INSURANCE INFORMATION

☐ Uninsured **Insurance Type:** ☐ Commercial/Private ☐ Medicare ☐ Medicaid ☐ Medicare Advantage ☐ Veterans Affairs (VA) ☐ Other

HEALTH PLAN INFORMATION

Plan Name: ______

Plan Phone Number: ___-___-____

Beneficiary Name: ______

Beneficiary Date of Birth: __ / __ / ____

Policy ID: ______ **Group No.:** ______

SECONDARY INSURANCE INFORMATION (optional)

Plan Name: ______

Plan Phone Number: ___-___-____

Policy ID: ______ **Group No.:** ______

3 HEALTHCARE PROVIDER INFORMATION

Physician Name: ______ **Practice Name:** ______

Office Contact: ______ **Phone:** ___-___-____ **Fax:** ___-___-____ **Email:** ______

Address: ______ **City:** ______ **State:** ___ **ZIP:** ______

Prescriber Tax ID: ______ **UPIN/NPI:** ______

If administering practice differs from provider practice, complete this section with administering practice information:

Office Contact: ______ **Phone:** ___-___-____ **Fax:** ___-___-____ **Email:** ______

Address: ______ **City:** ______ **State:** ___ **ZIP:** ______

Prescriber Tax ID: ______ **UPIN/NPI:** ______ **SGLN Number:** ______

4 PHYSICIAN ATTESTATION

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

Physician Signature: ______________________ **Date:** __ / __ / ____

Must be a physical signature.

5 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.

Name: ______ **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, parent, court-appointed legal guardian). Healthcare office staff cannot sign on behalf of the patient.

Representative Name: ______ **Phone:** ___-___-____

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 therein. **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 Injectafer® (ferric carboxymaltose injection) is medically appropriate and have explained the reasons for doing so to my patient. I also agree to submit requests to AR Assist on behalf of my patient so that his or her eligibility can be evaluated to determine access to various assistance programs.

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 AR Assist 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 AR Assist or its 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 AR Assist programs, 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 Injectafer has been prescribed for my patient. I understand that American Regent, Inc., a parent company of AR Assist, reserves the right to change or terminate any AR Assist services (including the Injectafer Savings Program or Patient Assistance Program) at any time or to refuse to provide Injectafer to any patient under the Patient Assistance Program.

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

- No third party or patient can be charged for Injectafer under such program
- No free product should be sold, traded, or distributed for sale
- Any free drug provided is not contingent upon future purchase or prescribing of Injectafer

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 information about me (for example, my name, address, and insurance policy number) and my medical condition (for example, my diagnosis or medications) to AR Assist, and its third-party vendors, suppliers, and other service providers supporting AR Assist (herein described collectively as "service providers"). I authorize service providers supporting AR Assist 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. 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 a AR Assist support program, including the Injectafer Savings Program or the 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 Injectafer 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 the AR Assist services
- Provide support to appeal any insurance denials

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 AR Assist is a component of American Regent, Inc., a parent company of AR Assist, and that the service providers may be compensated by American Regent, Inc. My healthcare providers may also receive remuneration, or payment, for disclosing my information pursuant to this consent document.

Consent Terms

This consent will last for 3 years from the date on this form or until I am no longer receiving Injectafer or enrolled in any AR Assist 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 AR Assist. 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 AR Assist 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 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 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 Jersey, excluding New Jersey conflict of law rules, and applicable federal law.

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