

AMAG Assist™ Reimbursement Program – Enrollment Form

To enroll, please complete this form online and print it out *OR* print and complete by hand, then fax to *AMAG Assist* at 866-470-5871. **If completing this form online you may not be able to save your changes, and may wish to retain a printed copy for your records.** Should you have any questions, please call *AMAG Assist* at 877-411-2510 and select option 2 between the hours of 9 AM and 7 PM EST. **Please note that the signed *AMAG Assist Release Form* must be received before services can be provided.**

AMAG Assist offers **claims tracking** to monitor the status of your *Feraheme™* (ferumoxytol) Injection For Intravenous (IV) use claims. This service confirms that claims are being processed appropriately by the payor. Would you like to enroll in this service? Yes No

Provider Information

Physician Name: _____
Facility Name: _____
Specialty: _____
Address: _____
City, State, ZIP: _____
Office Contact: _____
Phone: _____ Fax: _____
Tax ID: _____ NPI: _____
State License # (required for PAP): _____

Clinical Information

Patient Diagnosis: _____
Date of Diagnosis: _____
Is the patient currently on dialysis? Yes No
Is the patient currently on ESA therapy? Yes No
If yes, name of therapy: _____
Previous iron therapies: _____

Product Information

Drug: Feraheme
Dosage: _____
Estimated Treatment Start Date: _____
Product Shipping Address* (if different from above):

Patient Information

Patient Name: _____
Patient SS#: _____ DOB: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Contact Name (if other than patient): _____
Contact Phone: _____

Patient Insurance Information

Medicare Eligible? Yes No Date: _____
Primary Insurance Company: _____
Insurance Phone Number: _____
Policy #: _____ Group #: _____
Name of Insured: _____
Secondary Insurance Company: _____
Insurance Phone Number: _____
Policy #: _____ Group #: _____
Name of Insured: _____
For insured patients: How will *Feraheme* be supplied?
Office Inventory Specialty Pharmacy

Patient Financial Information*

Annual Household Income: _____
Number Living in Household: _____

Items denoted by an asterisk (*) are required for Patient Assistance Program applications only.

Completion of the **AMAG Assist Release Form** is also required before services can be provided.

AMAG Assist™ – Release Form

Please fax the completed form to *AMAG Assist* at 866-470-5871. Should you have any questions, please call *AMAG Assist* at 877-411-2510 and select option 2 between the hours of 9 AM and 7 PM EST. **Please note: this signed form must be received before services can be provided.**

Patient Name: _____ **Patient DOB:** _____

Patient Authorization

I authorize my insurance company, employer, hospital, physician, pharmacy, or any other health care provider or payor to share or disclose to AMAG Pharmaceuticals, Inc. and its vendors, representatives, or agents (collectively, "AMAG") my relevant medical and financial information, including personal information, for the purpose of my participation in *AMAG Assist*.

I also authorize AMAG to use and disclose any such records and information to any necessary persons or entities for the purpose of my participation in *AMAG Assist* and the overall administration of the program. I understand that my information will be treated confidentially to the extent required by law. AMAG may use or disclose my information to refer me to, or to determine my eligibility for, other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my *Feraheme™* (ferumoxytol) Injection For Intravenous (IV) use or related treatments or therapies.

Except as may be required or permitted by law, I understand that any information that reveals my identity will not be used for any purpose other than for this program unless I give my written consent to AMAG. I verify that the information provided in this application is complete and accurate. I understand that AMAG reserves the right at any time and without notice to modify or discontinue *AMAG Assist* (including any assistance provided to me) and the related eligibility criteria. I certify that I am a resident of the United States. I have read, understand, and agree to all of the above.

Patient Signature: _____ **Date:** _____

Provider Authorization

I represent that the information contained in this application is complete and accurate to the best of my knowledge. I understand that AMAG Pharmaceuticals, Inc. reserves the right to modify or terminate the *AMAG Assist* program at any time and without notice. My signature certifies that *Feraheme* provided by *AMAG Assist* will not be resold or offered for sale, trade, or barter and will not be returned for credit. I understand that AMAG reserves the right to recall the product if necessary. I understand that I am under no obligation to prescribe any AMAG products to participate in *AMAG Assist* and that I have not received, nor will receive, any benefit from AMAG for prescribing an AMAG product. I understand that AMAG is not responsible for filing claims and that all final decisions on diagnosis, the need for treatment and the appropriateness of *Feraheme* for a particular patient rest with me as the patient's provider. I agree to abide by this certification throughout my participation in *AMAG Assist*.

Print Provider Name: _____

Provider Signature: _____ **Date:** _____