AMAG ASSIST™
REIMBURSEMENT PROGRAM – ENROLLMENT 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, option 2, between the hours of 9 AM to 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) claims. This service confirms that claims are being processed appropriately by the payer. Would you like to enroll in this service? **Yes** ❑ **No** ❑

PROVIDER INFORMATION

Physician Name:

Facility Name:

Specialty:

Address:

City: State: ZIP:

Office Contact:

Email:

Phone: Fax:

Tax ID: NPI:

State License # (required for PAP):

CLINICAL INFORMATION

Patient Diagnosis:

Primary

Secondary

Date of Diagnosis:

Is the patient currently on dialysis? Yes ❑ No ❑

Is the patient intolerant to oral iron? Yes ❑ No ❑

Has the patient had unsatisfactory response to oral iron? Yes ❑ No ❑

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:

Relationship to patient

Secondary Insurance Company:

Insurance Phone Number:

Policy #: Group #:

Name of Insured:

Relationship to patient

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

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Patient Name: **Patient DOB:**

PATIENT AUTHORIZATION

I authorize my insurance company, employer, hospital, physician, pharmacy, or any other health care provider or payer 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) 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 ferumoxytol 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:**