Please fax the completed form to AMAG Assist at 877-591-2505. Should you have any questions, please call AMAG Assist at 844-635-AMAG (2624) between the hours of 8 am and 6 pm EST. **Please note that the signed AMAG Assist Authorization Form must be received before services can be provided. Items denoted by an asterisk (*) are required for Patient Assistance Program applications only.**

AMAG Pharmaceuticals, Inc. | 1100 Winter Street | Waltham, MA 02451

PP-FRH-US-00161

AMAG Assist® Patient Enrollment Form

STEP 1 Complete Patient & Insurance Information

Patient Information

Patient Name: Patient Sex: Male ❑ Female ❑

DOB:

Address:

City: State: Zip:

Phone:

Patient Insurance Information **Patient does not have insurance ❑**

Medicare eligible? Yes ❑ No ❑ Date:

Primary insurance:

Insurance phone number:

Policy #: Group #:

Name of insured: Relationship to patient:

Secondary insurance:

Insurance phone number:

Policy #: Group #:

Name of insured: Relationship to patient:

Patient financial information*

Annual household income: Number living in household:

STEP 2 Read and Sign Voluntary Patient Information

Patient authorization

By signing this form, I authorize my health plans, health care providers and staff, and pharmacies to disclose to AMAG Pharmaceuticals, Inc. and its vendors, representatives, or agents (collectively, "**AMAG**") my relevant personal health information, including, but not limited to, information relating to my medical conditions, treatment, care management, and health insurance ("PHI"), as well as all information provided on this form and any prescription or by me directly (together, with PHI, "**My Information**") for the purpose of my participation in AMAG Assist programs.

I also authorize AMAG to use and disclose My Information 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 or alternate sources of funding or coverage that may be available to provide financial assistance to me for 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** _____

Feraheme® is an iron replacement product indicated for the treatment of iron deficiency anemia (IDA) in adult patients:
- who have intolerance to oral iron or have had unsatisfactory response to oral iron or
- who have chronic kidney disease (CKD).

Feraheme is contraindicated in patients with known hypersensitivity to Feraheme or any of its components; history of allergic reaction to any intravenous iron product.

WARNING: RISK FOR SERIOUS HYPERSENSITIVITY/ANAPHYLAXIS REACTIONS

Fatal and serious hypersensitivity reactions including anaphylaxis have occurred in patients receiving Feraheme. Initial symptoms may include hypotension, syncope, unresponsiveness, cardiac/cardiorespiratory arrest.
- **Only administer Feraheme as an intravenous infusion over at least 15 minutes and only when personnel and therapies are immediately available for the treatment of anaphylaxis and other hypersensitivity reactions.**
- **Observe for signs or symptoms of hypersensitivity reactions during and for at least 30 minutes following Feraheme infusion including monitoring of blood pressure and pulse during and after Feraheme administration.**
- **Hypersensitivity reactions have occurred in patients in whom a previous Feraheme dose was tolerated.**

Please see additional Important Safety Information and full Prescribing Information at Feraheme.com.

STEP 3 Prescriber Information

Prescriber information

Prescriber name:

Facility name:

Specialty:

City: State: Zip:

Office contact:

E-mail:

Phone: Fax:

Tax ID: NPI:

State license # (required for PAP):

Provider authorization

By signing below, I certify that (1) the information contained in this application is current, complete and accurate to the best of my knowledge; (2) the above therapy is medically necessary for the patient listed above and that I am authorized to prescribe and dispense the requested medication; (3) I have obtained from my patient all required written authorizations for the release of my patient's personal identification, medical and insurance information to AMAG Pharmaceuticals, Inc. and its vendors, representatives, or agents (collectively, "**AMAG**") for benefits verification and coordination of benefits; and (4) any prescription products received from AMAG Assist will be used for the above named patient only and will not be resold nor offered for sale, trade or barter and will not be returned for credit, nor will payment be sought from any payer, patient or other source for product received from AMAG Assist.

I understand that any information provided on this form is for the sole use of AMAG Assist to verify my patient's insurance coverage, to assess, if applicable, my patient's eligibility for participation in the patient assistance program and to otherwise administer the AMAG Assist program and related services. I understand that I am under no obligation to prescribe any *AMAG Pharmaceuticals* products to participate in AMAG Assist and that I have not received, nor will I receive, any benefit from AMAG for prescribing an AMAG product.

I understand that AMAG reserves the right to modify or terminate the AMAG Assist program at any time and without notice. I understand that AMAG reserves the right to recall the product if necessary and 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: _____

STEP 4 Patient Diagnosis

Patient diagnosis: Primary: Secondary:

Product, Administration, and Diagnosis Codes*

HCPCS[1]	Injection, ferumoxytol, for treatment of IDA, 1 mg **Q0138** non-ESRD use **OR Q0139** ESRD on dialysis
Drug administration CPT® codes[2†]	**96365** Intravenous infusion, for therapy, prophylaxis, or diagnosis specify substance or drug); initial, up to 1 hour
National Drug Codes (NDC)[3‡]	**59338-0775-01** FERAHEME 510 mg/17 mL, 1 vial; **59338-0775-10** FERAHEME 510 mg/17 mL, 10 vials
Diagnosis codes (ICD-10)[4]	D50.0 Blood loss (chronic); D50.1 Sideropenic dysphagia; D50.8 Poor iron absorption; D50.9 Iron deficiency
D50.0 ❑	**Confirm iron deficiency before using the following codes:**
D63.0 ❑	D63.0 Anemia in neoplastic disease - CODE NEOPLASM FIRST; D63.1 Anemia in chronic kidney disease - CODE CKD STAGE
D63.8 ❑	D63.8 Anemia in other chronic diseases classified elsewhere - CODE UNDERLYING DISEASE FIRST
D64.81 ❑	D64.81 Antineoplastic chemotherapy-induced anemia

* This table is provided for informational purposes only. Correct coding is the responsibility of the provider submitting the claim for the item or service. Please check with the payer to verify codes and specific billing requirements. AMAG Pharmaceuticals, Inc. does not make any representation or guarantees concerning reimbursement or coverage for any service or item.

† CPT® is a registered trademark of the American Medical Association.

‡Payer requirements regarding 10-digit and 11-digit NDC may vary.

CKD: chronic kidney disease; NEC: not elsewhere classified; ICD: International Classification of Diseases.

References: 1. Centers for Medicare & Medicaid Services, US Department of Health and Human Services. HCPCS 2018 index. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Downloads/2018-HCPCS-Index.pdf. Updated February 15, 2018. Accessed April 9, 2018. 2. American Medical Association. Current Procedural Terminology 2017: Professional Edition. Chicago. IL: American Medical Association; 2016. 3. Feraheme [prescribing information]. AMAG Pharmaceuticals, Inc; February 2018. 4. Centers for Medicare & Medicaid Services. 2018 code tables and index. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-Table-And-Index.zip. Accessed April 9, 2018.

Feraheme® (ferumoxytol injection) AMAG Assist® Patient Enrollment Form Checklist

□ Include a copy of both sides of the patient insurance card(s)

□ Check “patient does not have insurance” if the patient is uninsured

□ Ensure both you and your patient signs the enrollment Form (see Step 2 & 3)

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

□ **Fax completed form and insurance cards (front and back) to: 1-877-591-2505**

Have questions? Connect with us.

Call 1-844-635-AMAG (2624) (Monday–Friday, 8 AM–6 PM ET)

We are committed to helping ensure your patients receive treatment in a timely manner. If you haven’t received a call from AMAG Assist within 1 business days of sending this fax please contact AMAG Assist.

Feraheme®
ferumoxytol
injection