FERAHEME Enrollment Form

Fax completed form and medical and pharmacy insurance card(s) (front and back) to 877-591-2505.

STEP 1 Complete Patient & Insurance Information

Patient Name: _____ DOB: _____ Patient Sex: Male ❑ Female ❑

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____

Mobile Phone: _____ Alternative Phone: _____

Best Time to Contact: ❑ Morning ❑ Afternoon ❑ Evening Primary Language (if not English): _____

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: _____

Annual Household Income: _____ Number Living in Household: _____

❑ **Patient does not have insurance and should be evaluated for Patient Assistance Program** (Complete step 6)

STEP 2 Read and Sign Voluntary Patient Information

Patient Authorization

By signing this form, I authorize my health plans, health care Prescribers and staff, and pharmacies to disclose, in electronic or other form, 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 (Protected Health Information ("PHI")), as well as all information provided on this form and any prescription, or provided by me directly (together, with PHI, "My Information") for the purpose of my participation in Feraheme Assist programs.

I also authorize AMAG to use and disclose My Information for the following purposes (1) my participation in Feraheme Assist and the overall administration of the program; (2) to verify my insurance information; (3) to facilitate access to Feraheme Assist programs; (4) to refer me to, or determine my eligibility for other sources of funding; (5) to communicate with me, my health care Prescribers and health plan insurers about my medical care and treatment; (6) to provide me with informational and promotional material related to AMAG products and services and/or my treatment; and (7) to contact me for market research feedback. I understand that My Information will be treated confidentially to the extent required by law.

Except as may be required or permitted by law, I understand that any information that reveals my identity will not be used other than for the purposes stated in this "Patient Authorization" unless I give my written consent to AMAG. I understand that AMAG may review and publish de-identified information for legitimate business purposes.

This authorization expires at the end of my participation in the program or five (5) years after I sign it. I can cancel this authorization at any time. I understand that canceling the authorization, will not apply to any information already used through the authorization. I can revoke this authorization by writing to: AMAG c/o AllCare Plus Pharmacy, 50 Bearfoot Rd., Northborough, MA 01532.

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 Feraheme Assist (including any assistance provided to me) and the related eligibility criteria. I understand that my treatment, insurance enrollment, and eligibility for insurance benefits are not conditioned upon my signing this authorization. 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** _____

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

Signature of patient legal representative: _____ **Date** _____ **Relationship to patient:** _____

STEP 3 Prescriber Information

Prescriber Name: _____ Practice Name: _____

Specialty: ❑ Hematology ❑ Oncology ❑ Nephrology ❑ Gastroenterology ❑ Ob/Gyn ❑ Surgery ❑ Anesthesiology ❑ Other _____

Prescriber Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____ E-mail: _____

Direct Phone: _____ Fax: _____

Preferred Method of Communication: E-mail: ❑ Direct Phone: ❑ Fax: ❑ Best Time to Contact: ❑ Morning ❑ Afternoon

TaxID# _____ NPI: _____

State License #(required): _____ PTAN# _____ Medicaid# _____

STEP 4 Prescriber Authorization

Prescriber 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 personally identifiable health information, including diagnosis, treatment, medical and insurance information to AMAG Pharmaceuticals, Inc. and its vendors, representatives, or agents (collectively, "AMAG") for benefits verification and coordination of benefits, or to otherwise assist the patient to initiate or continue the prescribed therapy; and (4) any prescription products received from Feraheme 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 Feraheme Assist.

I understand that any information provided on this form is for the sole use of Feraheme 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 Feraheme Assist program and related services. I authorize AMAG to use or disclose the patient's health information contained on this form for such purposes.

I understand that I am under no obligation to prescribe any AMAG Pharmaceuticals products to participate in Feraheme 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 Feraheme 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 Prescriber. I agree to abide by this certification throughout my participation in Feraheme Assist.

Print Prescriber Name: _____

➔ **Prescriber Signature** _____ **Date** _____

STEP 5 Patient Diagnosis

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 or a history of allergic reaction to any intravenous iron product.

Patient on Dialysis: Yes ❑ No ❑

Primary Diagnosis:
❑ D50.0 ❑ D50.1 ❑ D50.8 ❑ D50.9 ❑ D63.0 ❑ D63.1 ❑ D63.8 ❑ D64.81 ❑ Other: _____

Secondary Diagnosis:
❑ D50.0 ❑ D50.1 ❑ D50.8 ❑ D50.9 ❑ D63.0 ❑ D63.1 ❑ D63.8 ❑ D64.81 ❑ Other: _____

D50.0 Blood loss (chronic); D50.1 Sideropenic dysphagia; D50.8 Poor iron absorption; D50.9 Iron deficiency

Confirm iron deficiency before using the following codes: D63.0 Anemia in neoplastic disease - CODE NEOPLASM FIRST; D63.1 Anemia in chronic kidney disease - CODE CKD STAGE; D63.8 Anemia in other chronic diseases classified elsewhere - CODE UNDERLYING DISEASE FIRST; D64.81 Antineoplastic chemotherapy-induced anemia

STEP 6 Complete Feraheme Prescription and Prescriber Authorization

Patient Name: _____ DOB: _____

❑ FERAHEME (ferumoxytol injection) 510 mg/17 mL **Dispense quantity:** 2 vials **Refills**: _____

Directions for use: Infuse 510 mg over at least 15 minutes at day 0 and repeat 3 to 8 days later. Dilute full contents of vial (17 ml) per product insert instructions before use.

Delivery Information (where product is shipped)

❑ Shipping Address is the same as step 3

Facility Name: _____ Facility Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Contact Name: _____

Infusion Setting: HCP Office ❑ Infusion Center ❑ Outpatient Hospital ❑ Other: _____

Letter of Affiliation

The physician listed in step 4 certifies that he/she is (a) affiliated with the entity and location listed in step 3, (b) will be responsible in all respects for the receipt and accountability of pharmaceutical products shipped to this entity at such location, and (c) will immediately notify AMAG Pharmaceuticals, Inc. if either of the foregoing statements is no longer true.

Print Prescriber Name: _____

➔ **Prescriber Signature** _____ **Date** _____

(Dispense as written)

➔ **Prescriber Signature** _____ **Date** _____

(Substitution allowed)

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**, including **Boxed Warning** at Feraheme.com.

Fax Completed Form and Insurance Card(s) (Front and Back) to 877-591-2505

Feraheme Assist™ Patient Enrollment Form Checklist

Complete the steps below to help ensure your patients have access to FERAHEME® (ferumoxytol injection) and prescriptions that are processed quickly.

- ❏ Include a copy of both sides of the patient medical and pharmacy insurance card(s)
- ❏ Check "patient does not have insurance" if the patient is uninsured to be evaluated for Patient Assistance Program
- ❏ Ensure both you and your patient sign the enrollment form (see steps 2, 4, and 6)

Have questions? Connect with us.

☎ **844-635-2624 (Monday - Friday, 8 AM - 8 PM ET)**

✉ **info@ferahemeassist.com**

If you or your patients are ever in doubt regarding the status of a FERAHEME enrollment form or have billing and reimbursement questions, please contact Feraheme Assist. We are committed to helping your patients receive treatment in a timely manner.

Feraheme® ferumoxytol injection

Please see additional **Important Safety Information** and full **Prescribing Information**, including **Boxed Warning** at Feraheme.com.

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Feraheme® ferumoxytol injection

FERAHEME Enrollment Form

Fax completed form and medical and pharmacy insurance card(s) (front and back) to 877-591-2505.

STEP 1 Complete Patient & Insurance Information

Patient Name: John Smith DOB: 3/11/80 Patient Sex: Male ☑ Female ☐

Address: 123 Main Street City: New York State: NY Zip: 10001

E-mail: Johnsmith@gmail.com

Mobile Phone: (212) 208-1312 Alternative Phone:

Best Time to Contact: ☑ Morning ☐ Afternoon ☐ Evening Primary Language (if not English):

Medicare Eligible? Yes ☐ No ☑ Date: 1/1/20

Primary Insurance: Healthcare Plan Insurance Phone Number: 212-555-1414

Policy #: 86254449 Group #: 342159

Name of Insured: John Smith Relationship to Patient: Self

Secondary Insurance: Insurance Phone Number:

Policy #: Group #:

Name of Insured: Relationship to Patient:

Annual Household Income: Number Living in Household:

☐ **Patient does not have insurance and should be evaluated for Patient Assistance Program** (Complete step 6)

STEP 2 Read and Sign Voluntary Patient Information

Patient Authorization

By signing this form, I authorize my health plans, health care Prescribers and staff, and pharmacies to disclose, in electronic or other form, 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 (Protected Health Information ("PHI")), as well as all information provided on this form and any prescription, or provided by me directly (together, with PHI, "My Information") for the purpose of my participation in Feraheme Assist programs.

I also authorize AMAG to use and disclose My Information for the following purposes (1) my participation in Feraheme Assist and the overall administration of the program; (2) to verify my insurance information; (3) to facilitate access to Feraheme Assist programs; (4) to refer me to, or determine my eligibility for other sources of funding; (5) to communicate with me, my health care Prescribers and health plan insurers about my medical care and treatment; (6) to provide me with informational and promotional material related to AMAG products and services and/or my treatment; and (7) to contact me for market research feedback. I understand that My Information will be treated confidentially to the extent required by law.

Except as may be required or permitted by law, I understand that any information that reveals my identity will not be used other than for the purposes stated in this "Patient Authorization" unless I give my written consent to AMAG. I understand that AMAG may review and publish de-identified information for legitimate business purposes.

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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 Feraheme Assist (including any assistance provided to me) and the related eligibility criteria. I understand that my treatment, insurance enrollment, and eligibility for insurance benefits are not conditioned upon my signing this authorization. I certify that I am a resident of the United States. I have read, understand, and agree to all of the above.

➔ **Patient Signature** John Smith **Date** 1/1/20

By signing, I certify that I have read and agree to the above Patient Authorization based on the support I have requested.

Signature of patient legal representative: **Date** **Relationship to patient:**

STEP 3 Prescriber Information

Prescriber Name: Fred Johnson Practice Name: General HP

Specialty: ☑ Hematology ☐ Oncology ☐ Nephrology ☐ Gastroenterology ☐ Ob/Gyn ☐ Surgery ☐ Anesthesiology ☐ Other

Prescriber Address: 456 Park Street

City: New York State: NY Zip: 10011

Office Contact: Megan Webster E-mail: mwebster@email.com

Direct Phone: (212) 123-4567 Fax: (212) 123-4564

Preferred Method of Communication: E-mail: ☑ Direct Phone: ☐ Fax: ☐ Best Time to Contact: ☑ Morning ☐ Afternoon

TaxID# NPI:

State License #(required): PTAN# Medicaid#

STEP 4 Prescriber Authorization

Prescriber 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 personally identifiable health information, including diagnosis, treatment, medical and insurance information to AMAG Pharmaceuticals, Inc. and its vendors, representatives, or agents (collectively, "AMAG") for benefits verification and coordination of benefits, or to otherwise assist the patient to initiate or continue the prescribed therapy; and (4) any prescription products received from Feraheme 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 Feraheme Assist.

I understand that any information provided on this form is for the sole use of Feraheme 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 Feraheme Assist program and related services. I authorize AMAG to use or disclose the patient's health information contained on this form for such purposes.

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Print Prescriber Name: Fred Johnson

➔ **Prescriber Signature** Fred Johnson **Date** 1/1/20

STEP 5 Patient Diagnosis

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- who have chronic kidney disease (CKD).

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

Patient on Dialysis: Yes ☐ No ☐

Primary Diagnosis:
☐ D50.0 ☐ D50.1 ☐ D50.8 ☐ D50.9 ☐ D63.0 ☐ D63.1 ☐ D63.8 ☐ D64.81 ☐ Other: ____

Secondary Diagnosis:
☐ D50.0 ☐ D50.1 ☐ D50.8 ☐ D50.9 ☐ D63.0 ☐ D63.1 ☐ D63.8 ☐ D64.81 ☐ Other: ____

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Delivery Information (where product is shipped)

☐ Shipping Address is the same as step 3

Facility Name: Facility Address:

City: State: Zip:

Phone Number: Contact Name:

Infusion Setting: HCP Office ☐ Infusion Center ☐ Outpatient Hospital ☐ Other:_____

Letter of Affiliation

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Print Prescriber Name:

➔ **Prescriber Signature** **Date**

(Dispense as written)

➔ **Prescriber Signature** **Date**

(Substitution allowed)

WARNING: RISK FOR SERIOUS HYPERSENSITIVITY/ANAPHYLAXIS REACTIONS

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- **Hypersensitivity reactions have occurred in patients in whom a previous Feraheme dose was tolerated.**

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