# Feraheme Patient Assistance Program
## Patient Application

To assess eligibility for participation in the Feraheme® (ferumoxytol injection) Patient Assistance Program, patients will need to provide income documentation to verify their household income and sign the below patient certification form. Please ensure healthcare provider has submitted a completed HCP Healthcare Provider (HCP) PAP Enrollment Form.

Income verification can include a recent copy of any of the following items:

- Federal tax return
- Unemployment or disability statements
- W-2
- An attestation letter from your treating physician if you have no source of income
- Social Security benefit statement
- Copy of your most recent paycheck stub

If any of the above forms of documentation are not available, the patient should call Feraheme Assist to understand what other forms of documentation may be acceptable.

☐ **Patient does not have insurance and should be evaluated for Patient Assistance Program**

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 Certification for Patient Assistance Program for Feraheme® (ferumoxytol injection):**

I hereby certify that I am not insured or that I am underinsured and do not have coverage for Feraheme. I understand that in order to be eligible to receive free product, my total income must be at or below 500% of the federal poverty level. I understand that I am not eligible to participate in the Patient Assistance Program if I am insured by a government-funded program (e.g. Medicaid, TRICARE, etc.). I also understand that AMAG Pharmaceuticals, Inc. and its vendors, representatives, or agents (collectively, "AMAG") will validate my financial information and may request proof of income or other financial documentation, which I agree to provide. If approved to participate in the Patient Assistance Program, I will not seek reimbursement for the medication from any insurer.

I understand that AMAG reserves the right at any time, and without notice, to modify or discontinue this program and any assistance provided to me. I further understand that AMAG reserves the right to make an independent determination of my financial and medical need. I agree to notify Feraheme Assist if (i) I obtain coverage through another source (federal, state, or private program), (ii) I no longer meet the income criteria for the program, or (iii) I find any errors in my application.

**Patient Name** _____

**Patient or Legal Guardian Signature** _____ **Date**_____

**Relationship to Patient** _____

Please see **Important Safety Information** on page 3 and Full Prescribing Information, including **Boxed Warning** at feraheme.com

## PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

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:** _____

# Feraheme® (ferumoxytol injection) Important Safety Information

**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 **Full Prescribing Information**, including **Boxed Warning** at feraheme.com

**Indication**

Feraheme is 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)

**What is the most important information I should know about Feraheme?**

Feraheme may cause serious side effects including:

- Serious allergic reactions that can lead to death. Serious allergic reactions have happened in people after receiving one dose of Feraheme or after receiving additional doses in people who did not previously have an allergic reaction. If you have a history of allergies to many different medicines, you may have an increased risk of serious allergic reactions to Feraheme. Tell your healthcare provider or get medical help right away if you get any of these signs or symptoms:
  - Rash
  - Itching
  - Dizziness or lightheadedness
  - Swelling of the tongue or throat
  - Wheezing or trouble breathing

**What is Feraheme?**

Feraheme is a prescription medicine used to treat iron deficiency anemia in adults who have:

- Intolerance to oral iron or who have not responded well to treatment with oral iron; or chronic kidney disease (CKD)

**Do not receive Feraheme if you:**

- Are allergic to Feraheme (ferumoxytol) or mannitol.
- Have had an allergic reaction to any iron medicine given by intravenous (IV) infusion.

**Before receiving Feraheme, tell your healthcare provider about all of your medical conditions, including if you:**

- Have allergies to many different medicines
- Have iron overload
- Have low blood pressure (hypotension)
- Are pregnant or plan to become pregnant. It is not known if Feraheme will harm your unborn baby.
- Are breastfeeding or plan to breastfeed. It is not known if Feraheme passes into your breast milk. You and your healthcare provider should decide if you will receive Feraheme or breastfeed.

**What are the possible side effects of Feraheme?**

Feraheme can cause serious side effects, including:

- **Serious allergic reactions.** Do not receive Feraheme if you are allergic to Feraheme (ferumoxytol) or mannitol
- **Low blood pressure (hypotension)** is a common side effect of Feraheme and can sometimes be serious. Your healthcare provider will check you for signs and symptoms of hypotension after each Feraheme infusion.
- **Iron overload.** Your healthcare provider will do blood tests to check your iron levels during treatment with Feraheme.

**The most common side effects of Feraheme include:** diarrhea, headache, nausea, dizziness, constipation, and swelling of your legs, feet, arms, or hands.

**ADVERSE REACTIONS**

To report SUSPECTED ADVERSE REACTIONS, contact Covis Pharma at 877-411-2510 or at medinfoUS@covispharma.com, or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

For more information, go to www.feraheme.com or call 1-877-411-2510.