



2012

Renassist® Insurance Verification Form & Patient Assistance Application

Please fax completed form to 877-363-6732 or e-mail to PAP@genzyme.com



Renvela® Tablets (800mg) Renvela® Powder (2.4g) Hectorol® Injection (2mcg/mL vial) Hectorol® Injection (4mcg/2mL vial)

Insurance Verification / Patient Assistance selection box with instructions.

PROVIDER INFORMATION

Provider information fields: Dialysis Unit Name, Unit Address, Unit Phone, etc.

PATIENT INFORMATION

Patient information fields: First Name, SSN, Street Address, City, State, Zip, etc.

INSURANCE DETAILS REQUIRED: FRONT AND BACK COPIES OF ALL INSURANCE CARDS

Insurance details fields: Primary Plan, Secondary Plan, Tertiary Plan, Medicare Beneficiaries, etc.

PATIENT RELEASE OF INFORMATION

Genzyme's Renassist program must have the patient's authorization to conduct a benefit verification and insurance research. By providing authorization, the patient ("you") permits Renassist and/or its affiliates to contact the insurer(s), including Medicare, about Chronic Kidney Disease (CKD) related therapies and allows the insurer(s) to disclose the relevant information about you to Renassist.

X PATIENT SIGNATURE: _____ DATE: _____

Phone: 1.800.847.0069 (M - F, 8:30am - 5:00pm EST) Fax: 1.877.363.6732 Email: PAP@genzyme.com Website: www.renassist.com



2012 Renassist® Patient Assistance Application

♦ ALL FIELDS are required for consideration. Missing information will cause processing delays. ♦

Patient Name: _____ DOB: _____

FINANCIAL INFORMATION	
2012 Limited Income Subsidy (LIS) Status	Applied for LIS? <input type="checkbox"/> Y <input type="checkbox"/> N Medicare Beneficiaries: If income is below 150% of the Federal Poverty Level, LIS Denial from SSA is required. Denial can be dated within 1 year of application received date.
Household Members	Self: <input checked="" type="checkbox"/> Spouse: <input type="checkbox"/> Y <input type="checkbox"/> N Number of additional dependents claimed on tax return: _____
Current Household ASSETS Combined assets for you, your spouse and dependents <small>(i.e. savings account, stocks, bonds; <i>excluding</i> primary residence, IRA, 401k)</small>	\$ _____
Monthly Household GROSS Income: BEFORE Deductions/Taxes Combined income for you, your spouse and dependents <small>(i.e. wages/employment, social security, retirement, pension, Veteran's benefits, aid for dependent children)</small>	\$ _____
Monthly Household NET Income: AFTER Deductions/Taxes Combined income for you, your spouse and dependents	\$ _____
Monthly Household Expenses Combined expenses for you, your spouse and dependents <small>(i.e. rent/mortgage, transportation, utilities, medications, food, insurance, car, loan and credit card payment)</small>	\$ _____
Household Out of Pocket Spend on All Prescription Drugs in 2012 REQUIRED: Pharmacy print out or EOB statement from Part D Plan verifying that \$1,000 has been spent in 2012. <input type="checkbox"/> Yes, proof is attached	FOR PART D BENEFICIARIES APPLYING FOR ASSISTANCE: \$ _____

Rx PRESCRIPTION FOR REQUESTED PRODUCTS	
Product	Sig/Directions
Renvela 800mg Tablets	___ # of tablets po with meals <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID ___ # of tablets po with snack(s) <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID
Renvela 2.4g Powder	___ # of sachets po with meals <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID ___ # of sachets po with snack(s) <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID
Hectorol Injection 2mcg/mL vial	
Hectorol Injection 4mcg/2mL vial	
<small>Product(s) to be filled for a 3 month supply with refills authorized for up to 1 year from original date of this prescription. Part D Assistance product will be supplied until 12/31/2012. Dispensing pharmacy may reduce quantities dispensed in accordance with program guidelines and program eligibility requirements. Product(s) will be shipped to the attention of Primary Contact at location noted on Page 1 unless otherwise prohibited.</small>	
PRINT PRESCRIBER NAME: _____	
X PRESCRIBER SIGNATURE: _____	DATE: _____ DEA #: _____

PATIENT ATTESTATION AND RELEASE OF INFORMATION

Genzyme's Renassist program must have the patient's authorization to determine eligibility for patient assistance and to conduct insurance research. By providing authorization, the patient ("you") permits Renassist and/or its affiliates (including American Kidney Fund, AKF) to: (1) share patient assistance eligibility information with Diplomat Specialty Pharmacy (for Part D patients), with AKF (for other patients), your dialysis unit, and prescribing physician and (2) to contact your insurer(s), including Medicare, about Chronic Kidney Disease (CKD) related therapies and allows the insurer(s) to disclose the relevant information to Renassist. Renassist may need to provide Diplomat Pharmacy, AKF, and the insurer(s), including Medicare, with your name, date of birth, Social Security Number, diagnosis, insurance information, or other relevant information about you. Renassist and AKF may also contact you directly for missing or additional information required to process this patient assistance request.

By signing below, I attest that the financial information I have provided is complete and accurate and I agree that AKF and/or Genzyme may verify this information. By signing below I also authorize Renassist to contact me directly in the future about available assistance programs, CKD treatment and therapies, and/or reimbursement and access related information.

X PATIENT SIGNATURE: _____ DATE: _____

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