

Please return this completed form by fax or email; contact Renasist directly for mailing address.

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

PROVIDER INFORMATION		
Submitting Facility Name:	Type of Facility: <input type="checkbox"/> Dialysis Unit <input type="checkbox"/> Physician's Office	
Facility Phone:	Facility Fax:	Tax ID #:
Facility Street Address:		
City:	State:	Zip Code:
Prescriber Name:		NPI #:
Primary Contact Name:	Title/Role:	
Primary Contact Email:		

SUBMISSION PURPOSE

(Please choose either insurance verification or patient assistance. Hectorol assistance is not available to Medicare Part D subscribers.)

<input type="checkbox"/> Insurance Verification Complete and submit Page 1, only. Do not submit financials and Rx. Patient signs and dates release of information below <i>(on Page 1)</i>	<input type="checkbox"/> Patient Assistance Complete Pages 1 & 2; sign & date in all applicable areas. Prescriber completes Rx for all applicable products on Page 2, signs & dates
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Check all products that apply for verification or assistance:

<input type="checkbox"/> Renvela® Tablets (800mg)*	<input type="checkbox"/> Hectorol® Injection (2mcg/mL vial)	<input type="checkbox"/> Hectorol® Capsules (0.5mcg)
<input type="checkbox"/> Renvela® Powder (2.4g)	<input type="checkbox"/> Hectorol® Injection (4mcg/2mL vial)	<input type="checkbox"/> Hectorol® Capsules (1mcg)
		<input type="checkbox"/> Hectorol® Capsules (2.5mcg)

*Renagel® (sevelamer hydrochloride) benefit verifications will be provided only when access limitations for Renvela apply.

PATIENT INFORMATION			
First Name:	Middle Initial:	Last Name:	
Social Security Number:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Phone:	Email:		
Street Address:		Apt. #:	
City:	State:	Zip Code:	
<input type="checkbox"/> Y <input type="checkbox"/> N Please add me to a patient contact list for information about renal, endocrine, and/or other Genzyme products related to my disease.			
PATIENT MEDICAL INFORMATION (Check all options that apply)			
Current Treatment	<input type="checkbox"/> In-center Hemodialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Non-Dialysis		
INSURANCE MEMBERSHIP (Check all options that apply)			
Insurance Types	<input type="checkbox"/> Medicare A and/or B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> Medicaid <input type="checkbox"/> Emergency Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance		
INSURANCE DETAILS (Complete section below OR attach front and back copies of insurance cards. If no insurance, move to next page.)			
Primary Insurance:		Secondary Insurance:	
Policy #:	Group #:	Policy #:	Group #:
Insurance Company Phone:		Insurance Company Phone:	
Policy Holder Name:		Policy Holder Name:	
Policy Holder Date of Birth:		Policy Holder Date of Birth:	

PATIENT RELEASE OF INFORMATION

Genzyme's Renal Reimbursement Helpline ("Helpline") must have the patient's authorization to conduct insurance research. By providing authorization, the patient ("you") permits the Helpline and/or its affiliates to contact the insurer(s) about ESRD related therapies and allows the insurer(s) to disclose the relevant information about you to the Helpline. The Helpline may need to provide the insurer(s) with your name, date of birth, Social Security number, diagnosis, insurance information, or other relevant information about you. If you understand the foregoing and authorize the release of the above information to Genzyme's Renal Reimbursement Helpline, please sign below. By signing below, I also hereby authorize the Helpline to contact me directly in the future about available assistance programs, ESRD treatment and therapies, and/or insurance related information.

X PATIENT SIGNATURE: _____ **DATE:** _____

Renasist Patient Assistance Application

IMPORTANT APPLICATION CONSIDERATIONS

- ◆ Renvela Medicare Part D Assistance Program Applications will not be accepted after 11/15/2011 ◆
- ◆ All fields on this page are required for consideration. Missing information may cause processing delays. ◆

Patient Name: _____ **DOB:** _____

PATIENT ELIGIBILITY INFORMATION *(Provide patient-specific responses to all of the following questions)*

Citizenship/Residency Status	United States Citizen: <input type="checkbox"/> Y <input type="checkbox"/> N Permanent Resident: <input type="checkbox"/> Y <input type="checkbox"/> N
Medicare Status	Applied for Medicare: <input type="checkbox"/> Y <input type="checkbox"/> N First Date of Dialysis <i>(if applicable)</i> : _____ Date Applied to Medicare: _____ Medicare Effective Date: _____
2011 Limited Income Subsidy (LIS) Status	Applied for LIS for 2011: <input type="checkbox"/> Y <input type="checkbox"/> N Approved for 2011 LIS: <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If N and income is less than 150% of FPL, attach proof of LIS denial)</i>

FINANCIAL INFORMATION

Total Number of Household Members <i>(including applicant and all persons that contribute to or are dependent on household income)</i>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> Other: _____
<i>All financial values below reflect the total of household members indicated above; including applicant. Reported financial information may include, but is not limited to, the examples listed below. All financial fields are required for consideration; use a zero when applicable.</i>	
Current Household Assets	◆ Checking Account ◆ Savings Account ◆ Stocks ◆ Bonds ◆
Monthly Household Income <i>Gross (before deductions) and Net (after deductions) values must both be included</i>	◆ Wages/Employment ◆ Social Security ◆ Retirement ◆ Pension ◆ Veteran's Benefits ◆ Aid for Dependent Children ◆
Monthly Household Expenses	◆ Rent/Mortgage ◆ Transportation ◆ Utilities ◆ Medications ◆ Food ◆ Insurance Payments ◆ Car, Loan, Credit Card Payment ◆

Current Assets	\$
Monthly Gross Income	\$
Monthly Net Income	\$
Monthly Expenses	\$

Rx PRESCRIPTION FOR PRODUCTS REQUESTED THROUGH PATIENT ASSISTANCE

Prescriber: Please complete the following fields for the available product(s) listed below. Illegible Rx's will be returned.

- ◆ Renvela® 800mg Tablets ◆ Renvela® 2.4g Powder ◆ Hectorol® 0.5mcg, 1mcg, 2.5mcg Capsules* ◆
- ◆ Hectorol® Injection (2mcg/mL vial)* ◆ Hectorol® Injection (4mcg/2mL vial)* ◆

**Please note that Hectorol is not available through Genzyme's Medicare Part D Assistance Program.*

Product	Strength	Sig/Directions <i>(Please indicate # of tablets/packets to be taken with meals and/or snacks for sevelamer products.)</i>

Product(s) to be filled for a 3 month supply with refills authorized for 1 year from original date of this prescription. Part D Assistance product will be supplied until 12/31/2011.
*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 Submitting Facility Address on Page 1 unless otherwise specified or prohibited.*

X PRESCRIBER SIGNATURE: _____ **DATE:** _____ **DEA #** _____
(Required) (Required) (Required)

PATIENT ATTESTATION AND RELEASE OF INFORMATION *(Signature and Date Required)*

Genzyme's Renal Reimbursement Helpline ("Helpline") must have the patient's authorization to conduct insurance research. By providing authorization, the patient ("you") permits the Helpline and/or its affiliates to contact the insurer(s) about ESRD related therapies and allows the insurer(s) to disclose the relevant information to the Helpline. The Helpline may need to provide the insurer(s) the with your name, date of birth, Social Security Number, diagnosis, insurance information, or other relevant information about you. The dialysis unit may already have your written consent to use your personal data for its reimbursement processing; however, the dialysis unit may need to obtain additional written authorization, in accordance with applicable state and federal regulations, to release that information to the Helpline and to allow for your insurer(s) to disclose information to the Helpline. By signing below you are authorizing the Helpline to contact you directly in the future about available assistance programs, ESRD treatment and therapies, and insurance related information.

By signing this document, I attest that the financial information I have provided is complete and accurate and I agree that the American Kidney Fund may verify this information. The Fund and/or the Helpline can also contact me directly with this information. I also agree that the Fund may disclose information contained in the application to my dialysis caregivers and/or its pharmacy vendors and the Genzyme Renal Reimbursement Helpline.

X PATIENT SIGNATURE: _____ **DATE:** _____

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