

Please Fax Completed Enrollment Form to 1-888-431-3403

| Section 1: Patient Information | | | | | |
|---|--------|---|--------------------------------------|---|--------------------|
| First Name: * | | | Last Name: * | | |
| Street Address: (NO P.O. BOXES, product will be shipped to patient's home) | | | | DOB: * | |
| City: | | State: | Zip: | Phone: * | Mobile Phone:* |
| Are you currently on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Is this a Fresenius Kidney Care patient? * <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Section 2: Patient Insurance Information | | | | | |
| Please select insurance type: <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Part: _____ <input type="checkbox"/> Medicaid <input type="checkbox"/> VA/Military Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> None | | | | | |
| Medical Insurance Company Name: <i>Please provide a copy of the patient's insurance card if available</i> | | | Member ID #: | | Phone Number: |
| Policy Holder Name: | | | Group #: | | BIN #: |
| Prescription Drug Coverage Company Name: <i>Please provide a copy of the patient's insurance card if available</i> | | | Member ID #: | | Phone Number: |
| Policy Holder Name: | | | Group #: | | BIN #: PCN: |
| Section 3: Prescriber and Dialysis Facility Information | | | | | |
| Prescriber Name: * | | | Dialysis Facility Name: | | |
| Practice Address: | | | Dialysis Facility Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| MD Office Contact Name: | | | Dialysis Facility Contact Name: * | | |
| Phone: * | | Fax: | Phone: * | | Fax: |
| MD Office Contact Email: | | | Dialysis Facility Contact Email: | | |
| Prescriber State License #: | | Expiration Date: | Prescriber NPI #: * | | Prescriber TAX ID: |
| Section 4: Phosphate Binder Treatment Information | | | | | |
| Diagnosis Code (ICD-10): <input type="checkbox"/> E83.39 <input type="checkbox"/> E83.30 <input type="checkbox"/> N18.6 <input type="checkbox"/> N25.0 <input type="checkbox"/> Other _ | | | Velphoro Daily Dosing: _____ Tablets | | |
| Current Calcium Lab Values: Date: _____ Value: _____ mg/dL | | Current Phosphorus Lab Values: Date: _____ Value: _____ mg/dL | | Current Ferritin Lab Values: Date: _____ Value: _____ | |
| Current TSAT Lab Values: Date: _____ Value: _____ | | Previous Therapy: <input type="checkbox"/> Sevelamer carbonate <input type="checkbox"/> Calcium acetate tablets <input type="checkbox"/> Velphoro <input type="checkbox"/> Sevelamer hydrochloride <input type="checkbox"/> Calcium acetate oral solution <input type="checkbox"/> Lanthanum carbonate <input type="checkbox"/> Calcium carbonate <input type="checkbox"/> Ferric citrate | | | |
| Additional Information: | | | | | |
| Section 5: Prescription Information | | | | | |
| Medication Name: * | | | Medication Quantity: * | | |
| Medication Refills: * | | | Days Supply: | | |
| Directions for use: * | | | | | |
| Prescriber Signature: * | | | Date Written: * | | |