

Please Fax Completed Application to: **1-866-496-8638**



Section 1: Patient Information			
First Name:	Last Name:	SSN:	
Street Address: <i>(NO P.O. BOXES, product will be shipped to patient's home)</i>			DOB: <i>(Patient must be 18 yrs or older)</i>
City:	State:	Zip:	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:	Member ID #:	Phone Number:	
Policy Holder Name:	Group #:	BIN #:	
Prescription Drug Coverage Company Name:	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:		
State License #:	Expiration Date:	NPI #:	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 _____	Current Calcium Lab Values: Date: _____ Value: _____ mg/dL	Current Phosphorus Lab Values: Date: _____ Value: _____ mg/dL	Velphoro Daily Dosing: _____ Tablets	
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: Authorization by HCP or Patient	
<p>FOR THE HCP: My signature below certifies that the person named on this application is a patient of this medical practice or dialysis clinic, as applicable, and is under the supervision of a physician or other healthcare professional. I understand the Velphoro Access Solutions program must have authorization to conduct a benefit verification and insurance research. By providing authorization, I permit RxCrossroads, Fresenius Medical Care North America's contractor, to contact the insurer(s), including Medicare, about Velphoro treatment, and allows the insurer(s) to disclose the relevant information about the patient.</p> <p>FOR THE PATIENT: My signature below certifies that I am a patient of this medical practice or dialysis clinic, as applicable, and am under the supervision of a physician or other healthcare professional. I understand the Velphoro Access Solutions program must have authorization to conduct a benefit verification and insurance research. By providing authorization, I permit RxCrossroads, Fresenius Medical Care North America's contractor, to contact my insurer(s), including Medicare, about Velphoro treatment, and allows the insurer(s) to disclose the relevant information.</p>	
_____ HCP Title (please print)	_____ Name of Practice/Dialysis Clinic
_____ HCP or Patient Signature	_____ Date

All applications are valid for twelve months from the prescriber's signature date or until December 31st, whichever comes first.

Please make a copy of this application for your records.

Program Phone Number: 1-877-774-6756

The documents included with this facsimile transmittal contain information from Fresenius Medical Care North America that is confidential and/or privileged. This information is intended to be for the use of the addressee named on this transmittal sheet. If you are not the addressee, note that any disclosure, photocopying, distribution or use of the contents of this faxed information is prohibited.

Velphoro Access Solutions will perform a benefit investigation and provide the patient's prescription insurance benefit to the dialysis facility and the physician's office, as well as provide pharmacy information as applicable. The patient's pharmacy will supply the product.

- Fill out the application.** To prevent processing delays, please complete all fields legibly in each section. This will assist with expediting and processing of the application. Fill out sections 1-4, and sign section 5.
- Please attach legible copies** (front and back) of the patient's pharmacy (PBM) insurance card(s) and medical face sheet. Make copies of both sides of the insurance card and prescription drug card large enough so that all the information is readable (especially ID number, contact phone number and address).
- Fax the completed application** to Velphoro Access Solutions at 1-866-496-8638.
- Case managers are available to answer questions between 8AM to 7PM ET at 1-877-774-6756.

Section 1: Patient Information

- The patient's information is required

Section 2: Patient Insurance Information

- This section allows your Velphoro Access Solutions case manager to explore all potential coverage options, including both primary and secondary pharmacy/PBM insurance
- Include all sources of medical and prescription coverage, including commercial, Medicare and Medicaid (if applicable)
- Member ID should include commercial, Medicare Part D, or Medicaid

Section 3: Prescriber Information

- Insurance companies require this information to provide benefit verification
- Please indicate the provider NPI, DEA, and State License numbers

Section 4: Prescription Information

- Be sure to check the correct lab values, dosing of Velphoro, as well as any prior therapies taken for benefit verification

Section 5: Benefit Verification Authorization

- Sign the application.** The Velphoro Access Solutions Application cannot be processed without signature from the HCP or patient (or patient's authorized representative).

The form is titled "Velphoro Access Solutions Application for Benefit Investigation Services" and includes the following sections:

- Section 1: Patient Information** - Fields for First Name, Last Name, SSN, Street Address, City, State, ZIP, Phone, and Date of Birth.
- Section 2: Patient Insurance Information** - Fields for Medical Insurance Company Name, Member ID #, Phone Number, Policy Holder Name, Group #, and Prescription Drug Coverage Company Name.
- Section 3: Prescriber and Dialysis Facility Information** - Fields for Prescriber Name, Dialysis Facility Name, Prescriber Address, Dialysis Facility Address, City, State, ZIP, MD Office Contact Name, Dialysis Facility Contact Name, Phone, Fax, MD Office Contact Email, and Dialysis Facility Contact Email.
- Section 4: Phosphate Binder Treatment Information** - Fields for Diagnosis Code (ICD-10), Current Calcium Lab Values, Current Phosphorus Lab Values, and Veforo Daily Dosing.
- Section 5: Authorization by HCP or Patient** - Signature lines for HCP Title, Name of Practice/Dialysis Clinic, and HCP or Patient Signature.

At the bottom of the form, there is a note: "All applications are valid for twelve months from the prescriber's signature date or until December 31st, whichever comes first. Please make a copy of this application for your records. Program Phone Number: 1-877-774-6756."

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