FRESENIUS RENAL PHARMACEUTICALS Rx SOLUTIONS

Velphoro Access Solutions
Application for Benefit Investigation Services

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

VELPHORO® (sucroferric oxyhydroxide) chewable tablets

VELPHORO Access Solutions

Is this a Renewal Benefit Investigation:
☐Yes ☐ No

Section 1: Patient Information

First Name:	**Last Name:**		**SSN:**
Street Address: *(NO P.O. BOXES, product will be shipped to patient's home)*			**DOB:** *(Patient must be 18 yrs or older)*
City:	**State:**	**Zip:**	**Phone:**
Are you currently on dialysis? ☐ Yes ☐ No	**Gender:** ☐ Male ☐ Female	**Is this a Fresenius Kidney Care patient?** ☐ Yes ☐ No	

Section 2: Patient Insurance Information

Please select insurance type: ☐ Commercial ☐ Medicare Part: _______ ☐ Medicaid ☐ VA/Military Benefits ☐ Other: ________________________________ ☐ None

Medical Insurance Company Name: *Please provide a copy of the patient's insurance card if available*	**Member ID #:**	**Phone Number:**	
Policy Holder Name:	**Group #:**	**BIN #:**	
Prescription Drug Coverage Company Name: *Please provide a copy of the patient's insurance card if available*	**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

If it is determined that a Prior Authorization is needed, Velphoro Access Solutions may initiate a Prior Authorization on your behalf.

Diagnosis Code (ICD-10): ☐ E83.39 ☐ E83.30 ☐ N18.6 ☐ N25.0 ☐ 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:	☐ Sevelamer carbonate	☐ Calcium acetate tablets	☐ Velphoro	☐ Sevelamer hydrochloride
	☐ Calcium acetate oral solution	☐ Lanthanum carbonate	☐ Calcium carbonate	☐ Ferric citrate
Additional Information:				

Section 5: Authorization by HCP or Patient

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 by McKesson, 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.

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 by McKesson, 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.

_______________________________________ _______________________________________
HCP Title (please print) *Name of Practice/Dialysis Clinic*

_______________________________________ ____________________________
HCP or Patient Signature *Date*

All applications are valid for twelve months from the HCP or Patient 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.
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FRESENIUS MEDICAL CARE
RENAL PHARMACEUTICALS

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VELPHORO Access Solutions

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Instruction Guide

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.

1. **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.
2. ***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).
3. ***Fax the completed application*** to *Velphoro Access Solutions* at 1-866-496-8638.
4. Case managers are available to answer questions between 8AM to 8PM 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).

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