Renassist℠: Genzyme's Reimbursement Services

Insurance Verification:
☐Renvela/Renagel
☐Hectorol Capsules ☐Hectorol IV

Non-Part D Patient Assistance:

☐Renvela
☐Hectorol Capsules ☐Hectorol IV

Provider Information (ALL FIELDS REQUIRED FOR CONSIDERATION)

Submitting Facility: Dialysis Unit ☐ MD Office ☐ Facility Name: ______________________________

Prescribing Physician (full name): ______________________________ Prescribing MD Zip Code: __________

SW/MD Office Contact: ______________________________ RD Contact: ______________________________

Facility Address: ______________________________ City: ______________ State: _____ Zip:__________

Phone: (__ __ __) __ __ __ - __ __ __ __ Fax: (__ __ __) __ __ __ - __ __ __ __ Tax ID: __ __- __ __ __ __ __ __ __

National Provider Identifier # for Unit/MD Office: ______________ Email address: ______________________

Patient Demographic Information (ALL FIELDS REQUIRED FOR CONSIDERATION)

First Name ☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐ Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Gender: Female ☐ Male ☐

Marital Status: ☐ S ☐ M ☐ D ☐ W

Date of Birth ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

Street Number ☐☐☐☐☐☐ Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Apt., P.O. Box (if any) ☐☐☐☐☐ City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip ☐☐☐☐☐

Phone Number ☐☐☐ ☐☐☐ ☐☐☐☐

Are you a US citizen? Yes ☐ No ☐ Permanent resident? Yes ☐ No ☐

Current Treatment: Pre-Dialysis ☐ Hemodialysis ☐ Peritoneal Dialysis ☐

Patient Health Insurance Verification Information (ALL FIELDS REQUIRED FOR CONSIDERATION)

Current Medications: Renagel® ☐ Renvela® ☐ PhosLo® ☐ Fosrenol® ☐ Tums® ☐ Zemplar® ☐ Hectorol® ☐ calcitriol ☐ Sensipar ☐

Have you applied for Medicare? Yes ☐ No ☐ If denied, reason denied Medicare: ______________________

Are you currently enrolled in Medicare? Yes ☐ No ☐ First date of dialysis: ____ / ____ / _____

Have you applied for the Limited Income Subsidy (LIS)? Yes ☐ No ☐ Did you receive LIS? Yes ☐ No ☐

	Medicare A or B*	Part D	Other Insurance	Other Insurance
PLAN NAME				
Insurance Co. Name				
Insurance Co. Phone #				
Effective Date				
Policy #				
Group/Plan #				
Subscriber's Name				
Subscriber's SSN				
Subscriber's DOB				
Relationship to Patient				
Subscriber's Employer				

***Enter Medicare Part A information first; If patient also has Part B, enter that information under "Other Insurance". If patient does NOT have Part A, enter Part B information in this column.**

PLEASE ATTACH A COPY (FRONT AND BACK) OF YOUR INSURANCE CARD(S)

Would you like to be added to a mailing list to receive information regarding Genzyme's Products and Programs for Patients with Kidney Disease? Yes ☐ No ☐

The Fund's Role in managing pharmacy programs does not imply product endorsement or liability for its use or misuse

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Patient Name________________________________

IF PATIENT IS A MEDICARE PART D SUBSCRIBER **DO NOT** FILL IN THIS SIDE FOR ASSISTANCE

IF PATIENT IS A MEDICARE PART D SUBSCRIBER PLEASE CONTACT RENASSIST

Have you previously applied to Renagel Patient Assistance Program? Yes ☐ No ☐ **Date:** ____________________

Have you previously applied to Hectorol Patient Assistance Program? Yes ☐ No ☐ **Date:** ____________________

For MD Offices Only: Does Patient wish to be contacted directly with Verification/Assistance Result? Yes ☐ **No** ☐

Complete information on all household members is required. Do not leave any fields blank; use a zero or dash wherever applicable.
Incomplete applications will not be considered.

Assets	
Checking Account(s)	$
Savings Account(s)	$
Stocks/Bonds	$
Total Current Assets*	$
Total Number of Household Members	
Monthly Income	
Patient's Monthly Take-Home Pay	$
Spouse's Monthly Take-Home Pay	$
Additional Income	
Social Security	$
Aid Received For Dependent Children	$
Retirement Income	$
Veteran's Benefits	$
Other (Specify)	$
Total Monthly Income**	$

Monthly Household Expenses	
Rent	$
Mortgage	$
Food	$
Telephone	$
Utilities (electric/gas/water)	$
Car Payment	$
Gasoline/Taxi/Bus	$
Credit cards	$
Loans	$
Other (Specify)	$
Monthly Medical Expenses	
Patient's Medication	$
Family Members' Medications	$
Monthly Insurance Expenses	
Health Ins. (include Dental)	$
Life Insurance	$
Car Insurance	$
Other Insurance	$
Total Monthly Expenses	$

*Do NOT include Total Current Assets in Total Monthly Income

**Total of Monthly Income and Additional Income (excluding Total Current Assets).

Attestation/Release of Information

☐ **I have reviewed the applicant's financial information on this form.**

Social Worker/MD Signature:______________________________________ **Date:**_________________________

Genzyme's Renal Reimbursement Helpline ("Helpline") must have the patient's consent to conduct insurance research. By providing consent, the patient authorizes the Helpline and/or its affiliates to contact the insurer(s) and allows the insurer(s) to disclose the relevant information to the Helpline. Helpline may need to provide to insurer(s) the patient's name, date of birth, Social Security number, diagnosis, insurance information, or other information. The dialysis unit may already have the patient's written consent to use his or her personal data for its reimbursement processing; however, the dialysis unit may need to obtain written authorization, in accordance with applicable state and federal regulations, to release that information to the Helpline and to allow for the patient's insurer(s) to disclose information to the Helpline. By signing this document, I attest that the financial information I have provided is complete and accurate and I agree that the Fund may verify 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.

Patient's Signature: ____ **Date**__________________________

Please return this completed form by Fax OR email
Contact Renassist directly for mailing information:

Phone: 1-800-847-0069 **Fax: 877-363-6732** **Email: PAP@genzyme.com**

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Renal Patient Assistance Program

VI. PRESCRIPTION SUBMISSION FOR RENVELA® (sevelamer carbonate) (send with application)

Prescription must be filled out and signed by the patient's treating physician (if DEA# is not available, please attach a copy of the prescribing physician's state license):

Prescribing Physician Full Name _______________ **Specialty** _______________

Facility Name _______________

Address _______________

City _______________ **State** _______________ **Zip** _______________

(____) _______________ **Phone**

(____) _______________ **Fax**

DEA# _______________ **Professional Designation** _______________

Patient Name _______________

Patient Date of Birth _______________

Patient Address _______________

City _______________ **State** _______________ **Zip** _______________

Rx:

Renvela 800mg, ______ # pills po; (QD☐) (BID☐) (TID☐) w/ MEALS;
CHECK ONE

AND _______# pills po; (QD☐) (BID☐) (TID☐) with SNACK(S).
CHECK ONE

Dispense up to 4 months supply. Dispense # __________

Physician Signature _______________ **Date** _______________

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Renal Patient Assistance Program

VI. PRESCRIPTION SUBMISSION FOR HECTOROL® (doxercalciferol) (send with application)

Prescription must be filled out and signed by the patient's treating physician (if DEA# is not available, please attach a copy of the prescribing physician's state license):

Prescribing Physician Full Name **Specialty**

Facility Name

Address

City **State** **Zip**

(____)____________________ (____)____________________

Phone **Fax**

DEA# **Professional Designation**

Patient Name

Patient Date of Birth

Patient Address

City **State** **Zip**

Rx:

Hectorol Capsules: 0.5mcg☐ 2.5mcg ☐ ,

Sig:_______ Capsules po; (QD☐) (TIW☐); Dispense up to 4 months supply.

↑ CHECK ONE ↑

Hectorol injection:

4mcg, Sig:_______ mcg IV TIW. Dispense up to 4 months supply.

Physician Signature **Date**

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VII. CHECKLIST

To expedite processing, please check off that the following have been completed before submitting application:

For Insurance Verifications:

- ☐ ALL required application fields have been completed
- ☐ Attached Front and Back copies of Insurance Card(s) including Medicare
- ☐ Applicant has signed Attestation/Release of Information Authorization

For Non-Part D Assistance (all of the above and below):

- ☐ IF APPLICANT PARTICIPATES IN A PART D PRESCRIPTION DRUG PLAN DO NOT USE THIS APPLICATION FOR ASSISTANCE.
  Contact Renassist for Renagel/Renvela Medicare Part D Assistance Program application.
- ☐ Prescription is filled out completely and signed by MD
- ☐ State MD license attached for any Rx without a DEA#
- ☐ Applicant has NOT been accepted for LIS assistance
- ☐ LIS denial letter is attached
- ☐ All reported income is in NET (not Gross) numbers (i.e., after taxes and other deductions)
- ☐ SW/MD has signed Attestation