Enrollment Form for AURYXIA® (ferric citrate)

Akebia cares

Phone 855-686-8601 | Fax 866-310-7424 | Email support@akebiacares.com

Akebia® THERAPEUTICS

PATIENT NAME (First, Middle, Last):	DATE OF BIRTH (MM/DD/YYYY):
	/ /

E PRESCRIBER INFORMATION

PRESCRIBER NAME:	PRESCRIBER PRACTICE NAME:	PRESCRIBER NPI:

PRACTICE ADDRESS:	STE#:	CITY:	STATE:	ZIP:

DIALYSIS FACILITY NAME (IF APPLICABLE):

DIALYSIS FACILITY ADDRESS (IF APPLICABLE):	STE#:	CITY:	STATE:	ZIP:

CONTACT PERSON:	CONTACT LOCATION:	TITLE:
	☐ PRESCRIBER ☐ DIALYSIS FACILITY	☐ RD ☐ RN ☐ PA ☐ SW ☐ NP ☐ LPN ☐ MA

CONTACT PHONE:	CONTACT FAX:	CONTACT EMAIL:
( ) - ☐ CELL ☐ OFFICE	( ) -	

F HEALTHCARE PROFESSIONAL SIGNATURE FOR BENEFITS VERIFICATION SERVICES (REQUIRED)

I attest that I am involved in the care and treatment of the patient and that I am making the below certifications and acknowledgements in consultation with and on behalf of the patient's prescriber. By signing below, I certify and acknowledge that (1) AURYXIA® is medically necessary and is in the best interests of the patient identified on this form; (2) the information in this form is accurate and complete to the best of my knowledge; (3) I am submitting this form to AkebiaCares to enroll the patient in AkebiaCares; (4) I am aware that the submission of this form to AkebiaCares does not guarantee that the patient will be eligible for AkebiaCares; (5) services provided by or on behalf of Akebia and/or AkebiaCares do not include the provision of treatment or medical advice or replace the treatment and care provided by the patient's prescriber; (6) any service provided by or on behalf of Akebia and/or AkebiaCares is not made in exchange for any express or implied agreement or understanding that the patient's prescriber will recommend, prescribe, or use AURYXIA® or any other Akebia product, and any decision to prescribe AURYXIA® was, and in the future will be, based solely on the prescriber's determination of medical necessity; and (7) I have obtained the required authorizations from my patient to release the referenced medical and/or other patient information relating to my patient's treatment to Akebia and AkebiaCares.

PRINT HEALTHCARE PROFESSIONAL NAME:	TITLE:

HEALTHCARE PROFESSIONAL SIGNATURE:	DATE: / /

G INCOME INFORMATION* (REQUIRED FOR PATIENT ASSISTANCE PROGRAM EVALUATION)

LAST 4 DIGITS OF SSN:	NO. OF PEOPLE IN HOUSEHOLD:	TOTAL ANNUAL HOUSEHOLD INCOME (BEFORE TAXES):
		$ (Include All Income: Wages, Pension, Social Security, Disability, Alimony, Interest/Dividends, Rental Property Income, etc)

*Akebia has the right to require written proof of income (such as a Form 1040, Form W-2, or other documentation) from patients in connection with a financial eligibility determination should the Automated Income Verification process produce invalid or no results.

H PRESCRIPTION INFORMATION (To ePrescribe, please select PharmaCord, using NABP/NCPDP (1836191) or NPI (1699202838)

PATIENT NAME (First, Middle, Last):	DATE OF BIRTH (MM/DD/YYYY):
	/ /

SELECT MEDICATION:	SHIP TO:	MEDICATION ALLERGIES? (IF YES, LIST ALL DRUG ALLERGIES):
☐ AURYXIA® (ferric citrate)	☐ PATIENT ☐ FACILITY (IF PERMITTED) ☐ PRESCRIBER	☐ YES ☐ NO

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☐ PATIENT ASSISTANCE PROGRAM	SIG/DIRECTIONS:	QUANTITY: 30-DAY SUPPLY	NO. OF REFILLS:
☐ STARTER OR BRIDGE THERAPY	SIG/DIRECTIONS:	QUANTITY: 30-DAY SUPPLY	NO. OF REFILLS:

CURRENT MEDICATIONS (PLEASE LIST OR ATTACH):

I PRESCRIBER SIGNATURE FOR PATIENT ASSISTANCE PROGRAM OR *STARTER/BRIDGE THERAPY* (REQUIRED)

I attest I am responsible for the care and treatment of the patient and that I am making the certifications and acknowledgments outlined in Section F.

PRINT PRESCRIBER NAME:	PRESCRIBER STATE LICENSE NUMBER:

PRESCRIBER SIGNATURE:	DATE: / /

Please see accompanying full Prescribing Information.

