Daiichi-Sankyo | access central

A single source for support

injectafer® ferric carboxymaltose injection

injectconnect™

INJECTAFER PATIENT ASSISTANCE PROGRAM
PRODUCT REQUEST FORM

DATE SUBMITTED: __ - __ - ____

INSTRUCTIONS

- Complete one form for each patient
- Complete all required fields
- Print the form
- Obtain physician signature
- Fax the completed form to 888-354-4856

Timing Notice
Submit this form **by the end of the business day on Wednesday** in order for the product to be shipped overnight the following Wednesday. (Holidays and weather may cause delays.)

IV IRON HOTLINE

877-4-IV-IRON
(877-448-4766)

www.DSIAccessCentral.com

Fax: **888-354-4856**

1 PROVIDER INFORMATION

Facility/Practice Name: **Physician Name:**

Office Contact: **Phone:** ___ - ___ - ____ **Fax:** ___ - ___ - ____

Shipping Address (where you prefer your replacement product to be sent):

City: **State:** **Zip:** *The Injectafer Patient Assistance Program ships replacement product to the provider.*

2 PATIENT INFORMATION

Patient Name: **Case Number:** **Date of Birth:** __ - __ - ____

Address (no PO boxes, please): **City:** **State:** **Zip:**

3 PRODUCT UTILIZATION

Injectafer® (ferric carboxymaltose injection)

Lot Number: **Dates of Administration:** __ - __ - ____ **Dosage per Day:** **Total Number of Vials Used:**

I have administered Injectafer, as indicated above, for the above patient to treat iron deficiency anemia. My patient has consented to my providing you this information. Neither the patient nor any third party was charged for Injectafer provided to this patient and for which replacement product is requested. In addition, I represent that the information contained in this form is complete and accurate to the best of my knowledge and agree to notify the Program of any changes I become aware of which could affect the eligibility of this patient.

Physician Signature: _____ **Date:** __ - __ - ____

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PP-US-IN-1229 09/19

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