Daiichi-Sankyo | access central

A single source for support

injectafer® ferric carboxymaltose injection

INJECTAFER PATIENT ASSISTANCE PROGRAM
PRODUCT REQUEST FORM

DATE SUBMITTED: / /

INSTRUCTIONS

- First, submit an Injectafer Patient Enrollment Form **prior** to Injectafer administration (available at DSIAccessCentral.com/hcp/injectafer/resources)
- Complete one Product Request Form for each patient
- Complete all required fields
- Print the form
- Obtain physician signature
- Fax the completed form to 833-471-9988

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.)

DAIICHI SANKYO ACCESS CENTRAL

1-866-4-DSI-NOW
(1-866-437-4669)

www.DSIAccessCentral.com

Fax: **833-471-9988**

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)

Select the NDC code and enter the information for the vial(s) used. Note, the second table is only required if there are multiple dates of administration.

Date of Administration:

Select the Product Administered (check if used)

Injectafer:	NDC 0517-0650-01 (750 mg)	NDC 0517-0602-01 (100 mg)
Lot Number:		
Dose Administered:		
Total # of Vials Administered:		

Date of Administration:

Select the Product Administered (check if used)

Injectafer:	NDC 0517-0650-01 (750 mg)	NDC 0517-0602-01 (100 mg)
Lot Number:		
Dose Administered:		
Total # of Vials Administered:		

I have administered Injectafer, as indicated above, for the above patient, based on my judgment of medical necessity, and I will be supervising the patient's treatment. 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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