



Enrollment Form for AURYXIA® (ferric citrate)

Phone 855-686-8601

Fax 866-310-7424

Email support@akebiacares.com



BENEFITS VERIFICATION ONLY

Complete sections A, B, C, D, and F.

Healthcare Provider Signature and Both Patient Signatures Required.

PATIENT ASSISTANCE PROGRAM

Complete all sections.

Prescriber Signature and Both Patient Signatures Required.

A PATIENT INFORMATION

NAME (First, Middle, Last):		SUFFIX:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH (MM/DD/YYYY):
PRIMARY PHONE: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> OTHER		EMAIL ADDRESS:			
STREET ADDRESS:		APT#:	CITY:	STATE:	ZIP:
PATIENT REPRESENTATIVE NAME:		RELATIONSHIP TO PATIENT:		IS THE PATIENT ON DIALYSIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PREFERRED PHARMACY (HELPFUL TO DETERMINE EXACT COST SHARE):			DOES THE PATIENT HAVE INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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)
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B PRESCRIBER INFORMATION

PRESCRIBER NAME:		PRESCRIBER CREDENTIALS:	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: <input type="checkbox"/> PRESCRIBER <input type="checkbox"/> DIALYSIS FACILITY		TITLE: <input type="checkbox"/> RD <input type="checkbox"/> RN <input type="checkbox"/> PA <input type="checkbox"/> SW <input type="checkbox"/> NP <input type="checkbox"/> LPN <input type="checkbox"/> MA	
CONTACT PHONE: <input type="checkbox"/> CELL <input type="checkbox"/> OFFICE	CONTACT FAX:	CONTACT EMAIL:		PREFERRED METHOD: <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE	

C PATIENT AUTHORIZATION TO USE AND SHARE PROTECTED HEALTH INFORMATION (REQUIRED)

By signing below, I authorize my healthcare providers, including my physicians and pharmacies ("My Providers"), and my health insurance plan ("My Plan") to use and share my identifiable medical information (such as information about my diagnosis and treatment) and my identifiable insurance information (collectively, "My Information") with Akebia Therapeutics, Inc., and its subsidiaries (including Keryx Biopharmaceuticals, Inc.), affiliates, representatives, agents, and contractors ("Akebia") so that Akebia can provide me with information, assistance, and support through AkebiaCares ("Patient Support") as described below; administer and analyze the effectiveness of AkebiaCares; ask if I am interested in participating in market research; carry out other business purposes related to AURYXIA®; and comply with law. I understand and agree that my pharmacies may receive payment from Akebia in exchange for sharing My Information with Akebia. Once My Information has been shared with Akebia, federal privacy laws may no longer protect the information. However, Akebia agrees to protect My Information by using and disclosing it only for purposes described in this authorization. I may refuse to sign this authorization and doing so will not affect my treatment, insurance coverage, or eligibility for benefits for which I am otherwise entitled. However, refusing to sign this authorization means that I cannot participate in AkebiaCares. I may cancel or revoke this authorization at any time by mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255 or by sending an email to support@akebiacares.com. If I revoke this authorization, My Providers and My Plan will stop using and sharing My Information, but my revocation will not affect uses and disclosures of My Information made in reliance upon this authorization prior to my revocation. This authorization expires ten (10) years from the date signed below, or earlier if required by state or local law, unless I revoke it before then. I will receive a copy of my signed authorization.

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME:	RELATIONSHIP TO PATIENT:
SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE:	DATE:

PATIENT NAME (First, Middle, Last):	DATE OF BIRTH (MM/DD/YYYY):
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D PATIENT CONSENT TO PARTICIPATE IN AkebiaCares (REQUIRED)

AkebiaCares is a program administered by Akebia that provides Patient Support to eligible patients who have been prescribed AURYXIA®. Patient Support includes: (1) providing reimbursement and financial support (such as investigating insurance coverage, confirming out-of-pocket costs, and reviewing eligibility for financial assistance); (2) working with patients and their healthcare providers to fill their prescriptions; and (3) providing patients with disease and medication-related educational resources and communications. By signing below, I confirm that I would like to enroll in AkebiaCares and that I want Akebia to provide me with Patient Support.

If I am applying for financial assistance, I also agree that Akebia can use the information provided on this form or otherwise provided by me directly or through My Providers (including my Social Security number, household information, and household income) to obtain credit reports about me from credit reporting agencies in order to verify the information, estimate my income, and determine my eligibility for financial assistance. Regardless of whether a credit report is obtained, Akebia has the right to require written proof of income (such as a Form 1040, Form W-2, or other documentation) from me in connection with a financial eligibility determination.

AkebiaCares is an optional program. I may withdraw from AkebiaCares at any time by mailing a letter to AkebiaCares, P.O. Box 5490, Louisville, KY 40255 or by sending an email to support@akebiacares.com. Akebia may use My Information and share it with My Providers or My Plan in connection with providing Patient Support and for the other purposes described in the authorization above. For example, Akebia may communicate with me (such as by mail, phone, or email) or my representative, use My Information to tailor AkebiaCares-related communications to my needs, and share information with My Providers about dispensing AURYXIA® to me. Akebia may de-identify My Information and use the de-identified information for Akebia's business purposes. If my insurance information changes at any time while I am participating in AkebiaCares, I will notify AkebiaCares as soon as possible.

PRINT PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE NAME:	RELATIONSHIP TO PATIENT:
SIGNATURE OF PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE:	DATE:

E PRESCRIPTION INFORMATION (FOR PATIENT ASSISTANCE PROGRAM ONLY)

SELECT MEDICATION:	SHIP TO:	SIG/DIRECTIONS:	QUANTITY:	NO. OF REFILLS:
<input type="checkbox"/> AURYXIA® (ferric citrate)	<input type="checkbox"/> PATIENT <input type="checkbox"/> FACILITY <input type="checkbox"/> PRESCRIBER			

MEDICATION ALLERGIES?
 YES NO (IF YES, LIST ALL DRUG ALLERGIES):

CURRENT MEDICATIONS (PLEASE LIST OR ATTACH):

To ePrescribe for the AkebiaCares PAP dispensing pharmacy, please select PharmaCord, using NABP/NCPDP (1836191) or NPI (1699202838).

F PRESCRIBER OR HEALTHCARE PROVIDER SIGNATURE (REQUIRED)

PRESCRIBER SIGNATURE IS REQUIRED FOR PATIENT ASSISTANCE PROGRAM IF REQUESTED SERVICES ARE LIMITED TO BENEFITS VERIFICATION, ANOTHER HEALTHCARE PROVIDER MAY SIGN

By signing below, I certify and acknowledge that (1) AURYXIA® is medically necessary and is in the best interests of the patient identified above; (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 me as the patient's healthcare provider; (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 I 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 my 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 PRESCRIBER NAME:	PRESCRIBER STATE LICENSE NUMBER:
PRESCRIBER SIGNATURE:	DATE:

If I am not the patient's prescriber (benefits verification only), I attest that I am involved in the care and treatment of the patient and that I am making the above certifications and acknowledgments in consultation with and on behalf of the patient's prescriber.

PRINT HEALTHCARE PROVIDER NAME:	TITLE:
HEALTHCARE PROVIDER SIGNATURE:	DATE:

Please click here for full Prescribing Information or go to Auryxia.com