AkebiaCares Re-enrollment Form

Akebia cares

Phone: 1-833-4AKEBIA (425-3242) | Fax: 866-310-7424

*Indicates required field (PLEASE CLEARLY TYPE OR PRINT IN BLACK INK)

A Patient information

Legal name (first, middle, last)*:	Gender*: ☐ Male ☐ Female	Date of birth (mm/dd/yyyy)*:	Are you a US citizen?* ☐ Yes ☐ No

Street address*:	Apt#:	City*:	State*:	ZIP*:

Primary phone*:	Patient/Patient representative email:

B Prescription drug insurance information (send a front and back copy of the patient's prescription insurance card or complete below)

Primary insurance*:	Rx PCN#*:	Rx BIN#*:	Rx Group#*:

Cardholder name*:	Prescription insurance member ID#*:	Medicare ID#*:	☐ Patient does not have insurance*

Name of patient-preferred pharmacy*:	Address*:

City*:	State*:	ZIP*:	Phone*:	Fax*:

C Income information† (required for Patient Assistance Program evaluation)

If you have Medicare Part D and have applied for Medicare's Low-Income Subsidy (Extra Help), which of the following outcomes did you receive?

☐ Full support ☐ Partial support ☐ Denied ☐ Did not apply

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)

†AkebiaCares or its agents will run a soft credit check to assist with income verification. A soft credit check will not appear on the patient's credit statement or impact their credit score. 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.

‡Your household size includes all individuals you reported on your U.S. Tax Return. If you did not file a tax return, please include all individuals that live with you.

D Prescriber information

Prescriber name*:	Prescriber practice name:	Prescriber NPI*:

Practice street address:	STE#:	City:	State:	ZIP:

Dialysis facility name (if applicable):

Dialysis facility address (if applicable):	STE#:	City:	State:	ZIP:

Contact person*:	Title*:

Contact phone*:	Contact fax*:	Contact email*:	Contact location*: ☐ Prescriber ☐ Dialysis facility

E Prescription information

Pharmacy Dispense			PAP or Starter/Bridge Therapy Dispense		
Select medication*:	Day supply*:	No. of refills*:	Select medication*:	Quantity (200 ct bottle)*:	No. of refills*:
☐ AURYXIA® (ferric citrate) tablets			☐ AURYXIA® (ferric citrate) tablets		
Sig/directions (please write clearly)*:			Sig/directions (please write clearly)*:		
Send Rx to*:			Ship to*:		
☐ Patient-preferred pharmacy			☐ Patient ☐ Facility (if permitted) ☐ Prescriber		
☐ Payer-preferred pharmacy			☐ Check to enroll in auto refill		

MEDICATION ALLERGIES? (IF YES, LIST ALL DRUG ALLERGIES)*:	CURRENT MEDICATIONS (PLEASE LIST OR ATTACH)*:
☐ YES ☐ NO	

F Prescriber signature (required)

Print prescriber name*:	Prescriber state license number*:

Prescriber signature*: X _____ (Dispense as written) X _____ (Substitutions allowed) Date*: _____

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