



Kepivance® Patient Assistance Program

Phone: 866-547-0644

Fax: 866-549-7219

Sponsor Form A

Instructions: This form should be completed by a Sponsor or a Kepivance Patient Assistance Program Specialist (only once per sponsor)

1. Sponsor (Facility) Information

Sponsor (Facility) Name		
Contact Person		
Title		
Address		
City	State	Zip
Phone		Fax
If your facility is part of a chain or group purchasing organization, please list the name:		

Please indicate if sponsor is a:		
<input type="checkbox"/> Physician Office	<input type="checkbox"/> Hospital/Hospital Pharmacy*	
<input type="checkbox"/> Dialysis Center Hospital Based Freestanding	<input type="checkbox"/> Home Dialysis Supplier	<input type="checkbox"/> Home Health Care
<input type="checkbox"/> Transplant Center*	<input type="checkbox"/> Infusion Center	
Physician/Facility License Number _____		

2. Product Shipping Information

Sponsor (Facility)Name		
Contact Person		
Title		
Address		
City	State	Zip
Phone		Fax

3. Sponsor Certification and Consent

By submitting this application, I agree to the following:

- I will provide Biovitrum products for patients in a medically appropriate manner based on current standards of medical care.
- I understand that Biovitrum reserves the right to change or terminate this program at any time, or to refuse to distribute Biovitrum products under this program to any patient or sponsor.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through the Kepivance® Patient Assistance Program.
- I understand that an insurance verification may be required to determine a patient's eligibility for the Kepivance® Patient Assistance Program.
- I understand that the product received through the Kepivance® Patient Assistance Program is for medically needy patients living in the United States and its territories.
- I certify that no third party or patient has been or will be charged for Biovitrum products for which replacement is sought from Biovitrum under the Kepivance® Patient Assistance Program. I further certify that all product received in connection with the Kepivance® Patient Assistance Program will replace such product; be furnished free of charge for treatment of needy patients who meet Kepivance® Patient Assistance Program criteria; and, that no part of any charges for Biovitrum products replaced under the Kepivance® Patient Assistance Program will be claimed as bad debt on any of _____ cost reports.
- I understand that Biovitrum's Kepivance® Patient Assistance Program is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- If I become aware of any changes in the patient's circumstances that affect Kepivance® Patient Assistance Program eligibility, I agree to notify the Kepivance® Patient Assistance Program immediately.
- I agree to release or make available to an authorized Biovitrum representative the medical and financial records for Kepivance® Patient Assistance Program patients at any time for the sole purpose of verifying patients' eligibility for the Kepivance® Patient Assistance Program, and I agree to obtain appropriate consent from each patient prior to releasing or making available to Biovitrum such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Sponsor Signature _____ Date: _____

Title _____

Send completed forms to: **Kepivance® Patient Assistance Program**

PO Box 66982

St. Louis, MO 63166-6982

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