

**Sponsor Form A**

**Instructions:** This form should be completed by a Sponsor or a Kepivance<sup>®</sup> Patient Assistance Program Specialist (only once per Sponsor).

**1. Sponsor (Facility) Information**

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

If your facility is part of a chain or group-purchasing organization, please list the name:

\_\_\_\_\_

Please indicate if the sponsor is a: \_\_\_\_\_ Physician Office \_\_\_\_\_ Hospital/Hospital Pharmacy\* \_\_\_\_\_ Community/Specialty Pharmacy  
\_\_\_\_\_ Dialysis Center: \_\_\_\_\_  
\_\_\_\_\_ Hospital-Based \_\_\_\_\_ Home Dialysis \_\_\_\_\_  
\_\_\_\_\_ Free-Standing \_\_\_\_\_ Supplier \_\_\_\_\_ Home Health Care \_\_\_\_\_ Transplant Center\*  
\_\_\_\_\_ Infusion Center

Physician/Facility License Number \_\_\_\_\_

\*The Kepivance<sup>®</sup> Patient Assistance Program cannot provide assistance for inpatient hospital use.

**2. Product Shipping Information**

Confirm address where product should be shipped (if different than above).

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

