injectafer® ferric carboxymaltose injection

injectconnect™

INJECTAFER SAVINGS PROGRAM
CHECK FAX REQUEST FORM

INSTRUCTIONS

- Complete all required fields
- Print the form
- Obtain patient signature
- Fax the completed form and the Explanation of Benefits (EOB) to 1-888-257-4673

The EOB provided must include the name of the insurance company, date of service, product name/J-code, and patient responsibility amount. To ensure appropriate approval, please attach all necessary supporting documents.

IV IRON HOTLINE

1-877-4-IV-IRON
(1-877-448-4766)

Fax: **1-888-257-4673**

Available Monday-Friday,
8:00 AM-5:00 PM ET

100 Passaic Ave., Suite 245
Fairfield, NJ 07004

Please check one box:

☐ Patient (check will be made payable to Patient Name and mailed to Patient Mailing Address)

☐ Practice/Physician (check will be made payable to Practice Name and mailed to Practice Mailing Address)

Patient Name:

Patient Mailing Address:

Patient Telephone Number: ___ - ___ - ____

Date of Service: __ - __ - ____

Injectafer Card ID: INJ

Amount Requested: $

Doctor Name:

Doctor Telephone Number: ___ - ___ - ____

This section should only be completed if the check is being mailed to a Physician or Practice.

Physician or Practice Name:

Mailing Address:

Signature: _____ **Date:** __ - __ - ____

Terms and Conditions: 1. This offer is valid for commercially-insured as well as cash paying patients. **2.** Depending on insurance coverage, eligible insured patients may pay no more than $50 for Injectafer for the first dose and $0 for Injectafer for the second dose, up to a maximum savings limit of $500 per dose, a $1,000 program limit per course of therapy. Check with your pharmacist or healthcare provider for your copay discount. Patient out-of-pocket expense may vary. **3.** This offer is not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or medical or prescription drug benefit program for retirees. **4.** The offer is valid for 2 courses, or 4 doses, of an Injectafer prescription. An explanation of benefits statement must be faxed in prior to transacting on the account numbers for assistance. One enrollment is allowed per 12-month period. **5.** Daiichi Sankyo, Inc. reserves the right to rescind, revoke, or amend this offer without notice. **6.** Offer good only in the USA, including Puerto Rico, at participating pharmacies or healthcare providers. **7.** Void if prohibited by law, taxed, or restricted. **8.** This account number is not transferable. The selling, purchasing, trading, or counterfeiting of this account number is prohibited by law. **9.** This account number is not insurance. **10.** By redeeming this account number, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer. **11.** Qualified patients receiving Injectafer will be allowed a 120-day retroactive enrollment period to receive benefits under the program rules.

Program managed by The Macaluso Group on behalf of Daiichi Sankyo, Inc. This program may be amended or terminated at any time without notice. Product dispensed only pursuant to program rules and federal and state laws. This is not insurance.

Confidentiality Notice: This form transmission is intended only for the addressee shown above. It may contain information that is privileged, confidential or otherwise protected from disclosure. Any review, dissemination or use of this transmission or any of its contents by persons other than the addressee is strictly prohibited. If you received this fax in error, please call us immediately upon receipt for instructions. Thank you for your cooperation.

Daiichi-Sankyo

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