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Product Replacement Form

Instructions for providers applying for product replacement through the Patient Assistance Program. This form should be completed by providers, not patients, and faxed to 1-833-471-9988.

Please follow these instructions to ensure that all necessary information is provided.
Patient must already be enrolled in the Patient Assistance Program and have been prescribed their medication:

- A copy of an invoice or documentation of purchase for product requested must be included
- For patients who have insurance, but whose insurer does not cover this product, include a copy of the initial claim denial and a copy of the appeal denial

A program representative will contact the provider's office once this Product Replacement Form has been received to review the request and provide information regarding the process.

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___/___/___
MM/DD/YYYY

Patient Address: _____ City: _____ State: _____ ZIP: _____

2. PROVIDER INFORMATION

Provider Name: _____

Provider License #: _____ Provider Tax ID #: _____ Provider NPI #: _____

3. REPLACEMENT PRODUCT

Product Name: _____

Dates(s) of Administration: _____

Diagnosis ICD-10 for the Date(s) of Service: _____

Vial(s) Administered: _____

4. ADMINISTRATION FACILITY/PROVIDER OFFICE ADDRESS

Place of Administration/Facility Name: _____ Office Contact: _____

Facility Address: _____
(Please provide a street address only, no PO boxes. Replacement product will be shipped to this facility address.)

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Product Replacement Form *(cont'd)*

5. PROVIDER DECLARATION

Provider Name: _____

I verify that the information provided on this application is complete and accurate. I understand that the patient must meet certain criteria to be eligible for assistance. The product administered to the above patient will be considered a donation to the patient from the Patient Assistance Program. I also understand that the product I receive is not a sample, but a replacement of product previously purchased. I understand that I will not receive any reimbursement from Daiichi Sankyo, or the Patient Assistance Program, whether for administration fees or otherwise. Aside from claims that have been denied, reimbursement for the cost of the product administered to the above patient on the date(s) indicated has not been sought and will not be sought from any source. Acceptance of this replacement product in no way obligates my facility to use the selected product for other patients. I verify that my decision to prescribe this product was the result of independent medical judgment and discretion.

Additionally, I understand that Daiichi Sankyo reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with the facility to protect an individual's medical privacy), of all entities receiving product replacement. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I represent and warrant that this facility has obtained all applicable authorizations, consents, and notices necessary to comply with all federal and state laws and regulations relating in any way to medical and/or health privacy, including, but not limited to, the HIPAA Privacy Rule, codified at 45 C.F.R. Parts 160 and 164, as amended from time to time. I understand that Daiichi Sankyo reserves the right to modify or revoke this program at any time without notice.

My signature confirms that this product was provided free of charge to this patient. I verify that to the best of my knowledge this information set forth in this application is complete and accurate. I agree to retain a copy of this form in the facility's records and to make it available upon request.

PROVIDER SIGNATURE: _____ Date: ___/___/___
MM/DD/YYYY

Fax the completed form to 1-833-471-9988.

Questions? Call 1-866-4-DSI-NOW (1-866-437-4669) Monday – Friday, 8 AM to 6 PM ET or visit DSAccessCentral4U.com

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