Daiichi Sankyo Open Care Program
P.O. Box 8409
Somerville, NJ 08876
Phone (866) 268-7327
Fax (866) 217-7171

Products Available:

Azor 10/20mg, 10/40mg, 5/20mg and 5/40mg
Benicar 5mg, 20mg, 40mg and Benicar HCT 20/12.5mg, 40/12.5mg, 40/25mg
Tribenzor 20/5/12.5mg, 40/10/12.5mg, 40/10/25mg, 40/5/12.5mg and 40/5/25mg
Welchol 625mg, Welchol OS 3.75g
Savaysa 15 mg, Savaysa 30 mg, Savaysa 60 mg

Initial Enrollment Instructions

- Patient Information Section must be completed and signed by the patient.
- Licensed Practitioner Section must be completed and signed by the practitioner (no stamps).
- The practitioner must complete the Prescription Section of the application, or include an original prescription written for a 12 month supply of the name brand medication.
- Attach a copy of the most recent federal tax return for the household**. If the patient does not file taxes, please attach other proof of annual household income (W-2/1099, social security, pension or disability statement, etc.) If the patient has zero income, please provide a letter signed by the prescribing physician or a patient advocate verifying their claim. Proof of household income is required annually for re-enrollment in the Daiichi Sankyo Open Care Program.**
- Fax **or** mail the application, prescription (if not using the Prescription Section on the application) and proof of annual household income to (866) 217-7171 or P.O. Box 8409 Somerville, NJ 08876.
- The patient will be advised in writing of any denied requests.
- **All incomplete and/or illegible applications will be returned to either the patient or practitioner for completion.**
- **PLEASE DO NOT INCLUDE ANY PATIENT MEDICAL INFORMATION / RECORDS WITH THIS APPLICATION.**

Refill/Reorder Instructions

- If the application submitted includes the Prescription Information Section, the practitioner may request a refill by phone via an automated refill system. Otherwise, a new application and prescription is required to be submitted by fax or mail every three months for a refill.
- Patient Information Section must be completed and signed by the patient.
- Licensed Practitioner Section must be completed and signed by the practitioner (no stamps).
- Fax **or** mail the application and prescription written for a 12 month supply of medication (if not using the Prescription Section on the application) to (866) 217-7171 or P.O. Box 8409 Somerville, NJ 08876.

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Program Eligibility

- Patient must be a legal resident of the United States.
- Patient cannot have any government prescription coverage such as Medicaid, Veteran's Administration, or any state or local programs, or any private prescription coverage such as an HMO or PPO plan.
- Patient cannot be enrolled in Medicare Part D.
- Patient's total annual **household** income must be at or below 200% of the Federal Poverty Level. See chart below for specific income amounts per household size

Household Size	Total Annual Household Income
1	$23,760
2	$32,040
3	$40,320
4	$48,600
5	$56,880
6	$65,160

*Note: Annual income for 48 contiguous states and the District of Columbia. If you live in Alaska or Hawaii, please visit the Families USA website at http://familiesusa.org/product/federal-poverty-guidelines.

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1. PATIENT INFORMATION

Name _____ SS#_____

Mailing Address _____ Date of Birth _____

City _____ State _____ Zip _____

Phone# (_____)_____

2. ELIGIBILITY

A. Is the patient a legal U.S. resident? □ YES □ NO
B. Is the patient enrolled in Medicare Part D? □ YES □ NO
C. Does the patient directly or indirectly (through other household members) have any other government prescription coverage? (ie; Medicaid, VA, state or local programs, etc.) □ YES □ NO
D. Does the patient directly or indirectly (through other household members) have any private prescription coverage? (ie: HMO, PPO, etc.) □ YES □ NO
E. What is your YEARLY HOUSEHOLD INCOME, including all wages, social security, pension, disability, etc.? $_____**YEARLY**
F. How many people, including the patient, live in the household? □1 □2 □3 □4 □5 □ 6+

Patient Certification and Authorization to Disclose Information

I verify that the information provided in this application is complete and accurate. I understand that Daiichi Sankyo, Inc. reserves the right to modify the application form or modify or discontinue this program and the related eligibility criteria at any time and without notice. I understand that I am expected to seek any available state or government assistance before reapplying to the Daiichi Sankyo Open Care Program. I authorize Daiichi Sankyo, Inc. and their authorized agent(s) to use the information on this application to process my request for medication from the Daiichi Sankyo Open Care Program and authorize the use of my Social Security number for identification purposes and record keeping only unless I give written consent. I also authorize Daiichi Sankyo, Inc. to use the information contained on this form to contact me or my healthcare provider to review my eligibility for the program and to confirm receipt of medications. I agree that I will contact the Daiichi Sankyo Open Care Program if any of the information regarding prescription drug coverage or insurance changes. I understand that I may revoke this consent and withdraw from participation in the program at any time by calling (866) 268-7327. I understand that my prescribing physician is responsible for choosing which prescription medication(s) is right for me, and that Daiichi Sankyo, Inc. is not responsible for verifying my medical condition or my prescribing physician's selection of products.

X_____

PATIENT SIGNATURE **Date**

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3. LICENSED PRACTITIONER SECTION

Practitioner Name_____ Phone # (_____)_____

Office Address _____ Fax # (_____)_____
(street address only, no P.O. Boxes)

City _____ State _____ Zip _____ Practitioner DEA # _____
(if no DEA # is available, please attach a copy of current state license)

4. PRESCRIPTION INFORMATION

Product 1 Name (if applicable):	Strength:	Quantity Per Day:	Refills: 1 year
Product 2 Name (if applicable):	Strength:	Quantity Per Day:	Refills: 1 year

I certify that the information provided in this application is complete and accurate to the best of my knowledge, that the product ordered hereunder is medically indicated for this patient, and that I will be supervising the patient's treatment. I understand and certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party (including, but not limited to, Medicare and any other governmental programs) shall be charged for such product. Additionally, no units of this product will be submitted for Medicare, Medicaid, or any public or private third party reimbursement, or returned for credit. I understand eligibility under this program is subject to the Daiichi Sankyo Open Care Program's approval and the patient's continuing compliance with all eligibility requirements, as set by Daiichi Sankyo, Inc. I agree to allow the Daiichi Sankyo Open Care Program or its authorized agent(s) to review the medical, financial, and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the program and the patient's receipt of any product(s) provided to him or her through the program. I have received a signed Patient Authorization to Disclose Protected Health Information from the above-named patient

X_____
LICENSED PRACTITIONER SIGNATURE (no stamps) Date

<u>*DO NOT INCLUDE PATIENT MEDICAL INFORMATION / RECORDS WITH THIS APPLICATION*.</u>

DSSV15001202
10/4/16