

ASTELLAS REIMBURSEMENT SERVICESSM
STOCK REPLACEMENT ASTELLAS ACCESS PROGRAMSM

To request stock replacement, please complete and fax form to Astellas Reimbursement ServicesSM
Phone: 1-800-477-6472 Fax: 1-866-317-6235

PHYSICIAN INFORMATION

Physician Name: _____
Facility/Practice Name: _____
Correspondence Address: _____
Shipping Address (if different): _____
Telephone: _____ Fax: _____
Physician DEA #: _____ Physician State License #: _____ Physician NPI: _____

PATIENT INFORMATION

Name: First _____ Last _____ Male Female
Mailing Address: _____
Daytime Phone: _____ Evening Phone: _____
 Patient does not have and is not eligible for any public or private health insurance.

PATIENT FINANCIAL INFORMATION

Please include income documentation for the patient's total household. Accepted forms must reflect current income, and be no older than 18 months. We reserve the right to deny the applicant if this information does not meet our criteria.

Size of Household: _____ Gross Family Annual Income: _____ Gross Family Annual Medical Expenses: _____

PRODUCT SELECTION AND ICD-9 DIAGNOSIS CODE INFORMATION

Adenoscan® (adenosine injection) ICD-9 Code: _____
 Ambisome® (amphotericin B) liposome for injection ICD-9 Code: _____
 Lexiscan® (regadenoson) injection ICD-9 Code: _____
 Mycamine® (micafungin sodium) for injection ICD-9 Code: _____
 Vaprisol® (conivaptan hydrochloride injection) ICD-9 Code: _____

REPLENISHMENT REQUEST

Setting of Care: Hospital Inpatient Hospital Outpatient Physician Office Other (please specify) _____
Date of Service(s): _____ Total Dosage Administered: _____

**FOR FULL PRESCRIBING INFORMATION SEE
WWW.ASTELLAS.COM OR CONTACT ASTELLAS
MEDICAL INFORMATION AT 1-800-727-7003.**

COMPLETE FORM ON REVERSE



Astellas Reimbursement ServicesSM

PLEASE COMPLETE TO INDICATE QUANTITY NEEDED FOR REPLENISHMENT

Product requested	Number of units
Adenoscan® (adenosine injection) 60mg (NDC# 00469-0871-20)	
Adenoscan 90mg (NDC# 00469-0871-30)	
Ambisome® (amphotericin B) liposome for injection [] mg (NDC# 00469-3051-30)	
Lexiscan® (regadenoson) Single-use prefilled syringe: 0.4 mg/5 mL (0.08 mg/mL) (NDC# 00469-6501-89)	
Lexiscan injection Single-use vial: 0.4 mg/5 mL (0.08 mg/mL) (NDC# 00469-6501-05)	
Mycamine® (micafungin sodium) for injection 100mg (NDC# 00469-3211-10)	
Mycamine 50mg (NDC# 00469-3250-10)	
Vaprisol® (conivaptan hydrochloride injection) 20mg/100mL (NDC# 00469-1602-11)	
Vaprisol [___ units] (NDC# 00469-1601-04)	

CERTIFICATION AND CONSENT

I am signing this application for the Astellas Access ProgramSM for Adenoscan, Ambisome, Lexiscan, Mycamine, or Vaprisol for a patient for whom the physician listed above has determined that the requested product was medically appropriate. I confirm that the information provided on this application is true and accurate. No reimbursement has been sought nor will it be sought for the requested product administered to the patient named above and I understand that the product received under this program is replacement product. I also understand that provision of free drug as part of this program is not contingent upon future purchase or prescribing of any Astellas product. I represent and warrant that I and my institution have the required patient consent and authorization to allow Astellas Pharma US, Inc., its affiliates and its agents ("Astellas") to view and share the medical, financial, and insurance records for this patient, in compliance with all federal and state privacy laws. I understand that Astellas reserves the right to change or terminate this program at any time, or to refuse to provide requested product through this program for any patient. I am authorized by the facility/hospital listed above to make this certification and sign this application.

Name (print):

Signature:

Title:

Date:

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Astellas Reimbursement Services[®]