



Daiichi-Sankyo

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
Evoxac 30mg
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

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.**

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.
- 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.**

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	\$22,340
2	\$30,260
3	\$38,180
4	\$46,100
5	\$54,020
6	\$61,940



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1. PATIENT INFORMATION

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Name _____

SS# _____

Mailing Address _____

Date of Birth _____

City _____ State _____ Zip _____

Phone# (____) _____

2. ELIGIBILITY

- A. Is the patient a legal U.S. resident?
B. Is the patient enrolled in Medicare Part D?
C. Does the patient directly or indirectly (through other household members) have any other government prescription coverage?
D. Does the patient directly or indirectly (through other household members) have any private prescription coverage?
E. What is your YEARLY HOUSEHOLD INCOME, including all wages, social security, pension, disability, etc.?
F. How many people, including the patient, live in the household?

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.

PATIENT SIGNATURE

Date

3. LICENSED PRACTITIONER SECTION

Practitioner Name _____

Phone # () _____

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

Fax # () _____

City _____ State _____ Zip _____

Practitioner DEA # _____
(If no DEA # is available, please attach a copy of current state license)

4. PRESCRIPTION INFORMATION

Table with 4 columns: Product Name, Strength, Quantity Per Day, Refills. Contains two rows for Product 1 and Product 2.

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.

LICENSED PRACTITIONER SIGNATURE (no stamps)

Date