

# ASTELLAS REIMBURSEMENT SERVICES<sup>SM</sup> STOCK REPLACEMENT ASTELLAS ACCESS PROGRAM<sup>SM</sup>

To request stock replacement, please complete and fax form to Astellas Reimbursement Services<sup>SM</sup>  
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 Services<sup>SM</sup>

**PLEASE COMPLETE TO INDICATE QUANTITY NEEDED FOR REPLENISHMENT**

<b>Product requested</b>	<b>Number of units</b>
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 Program<sup>SM</sup> 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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