Injectafer Savings Program
c/o TMG
100 Passaic Ave., Suite 245
Fairfield, NJ 07004
Program Help Desk: 866-741-7276
Program Fax: 888-257-4673

Injectafer Savings Program Check Fax Request Form

Please fax the Explanation of Benefits (EOB) form from the patient's insurance company to (888) 257-4673. Please ensure that the EOB provided includes the Name of the Insurance Company, Date of Service, Product Name/J-Code and Patient Responsibility amount. All the information above is required for check approval. Please ensure all necessary supporting documents are attached to ensure appropriate approval. All checks will be issued to the requesting entity.

Please call the Injectafer Savings Program help desk with any questions. Phone: (866) 741-7276 (9am – 5pm, EST) Monday – Friday, except holidays.

Patient Name: ____

Patient Mailing Address: ____

Patient Telephone Number: ______________________ **Date of Service:** ________________

Injectafer Card ID: INJ ______________ **Amount Requested:** ____________

Doctor's Name: __________________________ **Doctor's Telephone Number:** ______________

Signature of Patient: ____

Terms and Conditions: 1. This offer is valid for commercially-insured as well as cash paying patients. 2. Depending on insurance coverage, eligible insured patients may pay no more than $50 for Injectafer for the first dose and $0 for Injectafer for the second dose, up to a maximum savings limit of $500 per dose, a $1,000 program limit for coverage up to two doses. Check with your pharmacist or healthcare provider for your copay discount. Patient out-of-pocket expense may vary. 3.This offer is not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs, or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this card if they are Medicare-eligible and enrolled in an employer-sponsored health plan or medical or prescription drug benefit program for retirees. 4. The offer is valid for 1-course, or two doses, of an Injectafer prescription. An explanation of benefits statement must be faxed in prior to transacting on the account numbers for assistance. The account number may be used for additional course of therapy only after re-enrolling. One re-enrollment is allowed per 12-month period. 5. Daiichi Sankyo, Inc. reserves the right to rescind, revoke, or amend this offer without notice. 6. Offer good only in the USA, including Puerto Rico, at participating pharmacies or healthcare providers. 7. Void if prohibited by law, taxed, or restricted. 8. This account number is not transferable. The selling, purchasing, trading, or counterfeiting of this account number is prohibited by law. 9. This account number is not insurance. 10. By redeeming this account number, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer. 11. Qualified patients receiving Injectafer will be allowed a 30-day retroactive enrollment period to receive benefits under the program rules. Any patient wishing to receive this retroactive enrollment assistance must fill out the Eligibility Attestation Form to submit along with the claim from their initial treatment. This form must be completed prior to receiving any copay assistance.

Program managed by The Macaluso Group on behalf of Daiichi Sankyo, Inc. This program may be amended or terminated at any time without notice. Product dispensed only pursuant to program rules and federal and state laws. This is not insurance.

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