Patient Assistance Programs Enrollment Form

Application for appropriate patients to receive drug at little to no cost

How to complete this application:

1. Review the information on this page carefully and work with your doctor to complete pages 2 and 3 of the application.
2. Have your doctor fax your completed, signed application to **1-833-904-1851**. You may NOT fax the application yourself. You or your doctor may also mail the application to: **Patient Assistance Programs, PO Box 2355, Morristown, NJ 07962**
3. For patients who have insurance, but whose insurer does not cover **the selected drug***, include a copy of the initial claim denial and a copy of the appeal denial.

Please do not send your medical records or Statement of Medical Necessity form with your application.

Address:

PO Box 2355
Morristown, NJ 079629

Phone:

DATROWAY® (datopotamab deruxtecan-dlnk): 1-855-DATRO4U

ENHERTU® (fam-trastuzumab deruxtecan-nxki): 1-833-ENHERTU

Fax:

1-833-904-1851

What are the Patient Assistance Programs?

- The Patient Assistance Programs are offered by AstraZeneca/Daiichi Sankyo (AZ/DSI) to provide the drug* to qualifying patients at no cost. They are neither government programs nor insurance plans
- If you qualify, you may get the selected drug* for free for up to 1 year, depending upon the Program in which you are enrolled. AZ/DSI will send you an application for renewal once your enrollment ends
- The selected drug* will be sent to your doctor's office due to specific handling requirements
- The Programs can be changed or stopped by AZ/DSI at any time or for any reason

Do you qualify for the Programs?

You may qualify for the Programs if:

- You have been prescribed DATROWAY or ENHERTU by your physician
- You are a resident of the US
- You do not have insurance, private or government, that covers the selected drug* (excluding Medicare)
- You are not receiving any other assistance to help pay for the selected drug*
- Your annual income is at or below a certain level
- **If you are a Medicare Beneficiary**: You must have spent at least 3% of your annual household income on medicines in the current year

Important information about your application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

*DATROWAY or ENHERTU only.

Patient Assistance Programs Enrollment Form (cont'd)

PATIENT INFORMATION

For completion by Patient or Legally Authorized Representative

Please select drug:

☐ DATROWAY® (datopotamab deruxtecan-dlnk)
☐ ENHERTU® (fam-trastuzumab deruxtecan-nxki)

☐ New Application ☐ Re-enrollment

Name: _____ Gender: ☐ Male ☐ Female
First, Middle Initial, Last

Address: _____

City: _____ State: _____ ZIP _____ Date of Birth: ____/____/_____
MM / DD / YYYY

☐ Patient has no current address.

Phone: (____) _____ Mobile: (____) _____ Email: _____

Primary language spoken: ☐ English ☐ Spanish ☐ Other: _____

INSURANCE INFORMATION

Coverage Type: ☐ Uninsured ☐ Medicare ☐ Commercial ☐ Medicaid ☐ Other: _____

	Primary Medical Insurance	Secondary Medical Insurance	Pharmacy Insurance
Insurance Provider			
Insurance Phone #			
Cardholder Name (if not the patient)			
Cardholder DOB			
Policy #			
Group #			
BIN/PCN			

Diagnosis code: _____

Has the patient's employer, insurance plan, or their appointed representative directed you to seek enrollment in this program as a requirement of your drug coverage? ☐ Yes ☐ No

If you have coverage under Medicare, how much have you spent on medicines during the current year? $_____

INCOME:

What is the total combined household income before taxes? (Include yourself, all adults, and all dependents)
Income Verification: The Program and its authorized third-party agents will use your date of birth or social security number and/or additional demographic information as needed to access your credit information and information derived from public and other sources to estimate your income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact your credit score. The Program and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

$_____ Monthly OR $_____ Yearly

Number of people in your household: _____ Number of dependents in your household under 18 years of age: _____
(Include yourself, all adults, and all dependents)

Patient Assistance Programs Enrollment Form (cont'd)

CONSENT

I GIVE my doctor and the Programs administrators and their employees, agents, and contractors permission to verify my information to make sure it is true and complete; contact me by mail or phone about the Programs and about other products, programs, or services that might interest me or for which I may be eligible; contact me in order to ensure that I have received the medicines sent by the Programs.

I PROMISE that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have ANY prescription drug coverage that helps pay for or potentially helps pay for the requested medication (except for Medicare). Prescription drug coverage means any type of government health insurance program (except for Medicare) or private (commercial) insurance that may cover your medication, even if that coverage includes an alternate funding program (sometimes called specialty drug carve out) that requires you to first try to obtain your medicine from a third party or patient assistance program, like the Patient Assistance Programs; I will contact the Programs if any of my information about my prescription drug coverage or insurance changes.

I UNDERSTAND that the Program will use my Information to access my credit information and other sources to estimate my household income for Program eligibility. As a soft credit inquiry, this option will not impact my credit score.

I UNDERSTAND that my Information may be used to determine Program eligibility, administer and improve the Program, verify Program participation with health plans, including Medicare, and transition support to another manufacturer, when applicable.

I UNDERSTAND that I may be required to apply for prescription assistance through a government assistance program to maintain eligibility in the Programs.

I UNDERSTAND that I can call 1-855-328-7648 for DATROWAY or 1-833-364-3788 for ENHERTU at any time to withdraw from the Programs and/or cancel my permission to use my information. I can visit https://dsi.com/privacy-notice to review Daiichi Sankyo's Privacy Notice.

I UNDERSTAND that the Programs can request more information from me at any time; the Patient Assistance Programs can change or stop the Programs at any time or for any reason.

I UNDERSTAND that once my information has been disclosed to my doctor, federal privacy laws may no longer restrict its use or disclosure, but the Programs will only use my information as described in this form.

I MAY refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my health care provider will not change, but I will not have access to the Programs.

I GIVE the Programs, and the Programs' administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you).

This authorization form will be effective for 3 years unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

Signature of Applicant or Parent/Legally Authorized. If patient is a minor, parent or legally authorized representative should sign here.

Relation to Patient: ☐ Patient ☐ Parent/Legally Authorized Representative of Patient

I confirm I have read and understood the Patient Consent of this form and agree to the terms explained therein.

Sign Here _____ Date: ____/____/_____

MM / DD / YYYY

If someone helped you with this application and you want them to answer questions for you, please give us their name and phone number:

Helper's Name: _____ Helper's Phone: (____) _____

Patient Assistance Programs Enrollment Form (cont'd)

PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/_____
First, Middle Initial, Last *MM / DD / YYYY*

PRESCRIBER INFORMATION

For completion by Prescriber

This form will replace all previous prescriptions that may have been sent. All fields are required.

Prescriber Name: _____ Phone: (____) _____ Fax: (____) _____

Address: _____

City: _____ State: _____ ZIP: _____

Prescriber Email: _____ NPI: _____ State License Number (SLN): _____

Office Contact Name: _____ Phone: (____) _____ Practice Name: _____

Collaborating Physician Name (if applicable): _____

Administration Site: _____ Phone: (____) _____

Address: _____

Point of Contact Name: _____

PRESCRIPTION INFORMATION

Please select product: ☐ DATROWAY® (datopotamab deruxtecan-dlnk)
☐ ENHERTU® (fam-trastuzumab deruxtecan-nxki)

Infuse _____ mg/kg IV over _____ minutes once every 3 weeks.

Patient weight: _____ kg 100 mg in single-dose vial quantity: _____ Refills: _____

SHIP MEDICATION TO PRESCRIBER ONLY.*
PLEASE NOTE: Medications cannot be shipped to Post Office (PO) boxes.
*(*For Prescribers in Ohio ONLY: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station.)*

Sign Here Prescriber Signature: _____ Date: ____/____/_____
MM / DD / YYYY

Prescriber must comply with practicing state's specific prescription requirements, including but not limited to, electronic prescribing, state specific prescription form, etc. Noncompliance with state-specific requirements could result in outreach to prescriber by the pharmacy.

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