JourneyMate SUPPORT PROGRAM™ Brought to you by Mitsubishi Tanabe Pharma America

Dedicated Team. Patient-Focused Approach.

Request for Out-of-Pocket Assistance Reimbursement Form

Submission Fax Number: 1-888-506-0238
By Mail: JourneyMate Support Program™,
PO Box 2930, Phoenix, AZ 85062

Radicava® (edaravone) IV infusion 30mg/100mL

Please use this form if you've already paid your out-of-pocket costs to your infusion provider or specialty pharmacy. You may complete and submit this form to receive a check for reimbursement of applicable out-of-pocket costs following validation of all required information. This form may only be completed by the patient or the patient's Legal Representative. The patient is responsible for any amounts not covered by the Out-of-Pocket Assistance Program ("the Program").

If you are eligible for and enrolled in the Program, you may receive a check for reimbursement of your applicable out-of-pocket costs for your medication and your infusion costs for RADICAVA® (edaravone), or associated with the purchase/acquisition of RADICAVA®. For full Eligibility Requirements & Terms and Conditions, please refer to the Out-of-Pocket Assistance Program patient brochure, or visit radicava.com.

How to submit your reimbursement claim for applicable out-of-pocket costs:

1. **Complete sections A, B, and C, and sign and date Section D:**
   - You will need your Program Card information that was sent to you at the time of enrollment
2. **Include copies of the documents listed below:**
   - Explanation of Benefits (EOB) from your primary and secondary health insurance plans, if applicable. Required for medical reimbursement only
   - Invoice from your infusion provider or specialty pharmacy which includes:
     - Patient Name and Co-pay ID
     - Name and address of infusion provider or specialty pharmacy
     - Date(s) of Service or Purchase
     - RADICAVA® or healthcare procedure (HCPCS) code
     - Amount patient paid for RADICAVA® medication
     - Amount patient paid for IV infusion treatment, if applicable
   - Proof of payment by the patient to the infusion provider or specialty pharmacy for the patient's applicable out-of-pocket costs for RADICAVA® (eg, credit card receipt, photocopy of cleared check)
3. **Send the Request for Out-of-Pocket Assistance Form by fax or mail with EOB and proof of payment/receipt to the address above**

Section A: Patient Information			
Last Name	First Name		
Home Address			
Date of Birth (MM/DD/YYYY)	City	State	ZIP
Section B: Provider Information			
Last Name	First Name		
Address	City	State	ZIP
Section C: Claim Information			
Co-pay ID	Date of Service	Billed Amount	
Section D: Patient Signature			

I certify that, to the best of my knowledge, the information provided with and on this form is true and correct. By submitting this request, I certify that I have read the Eligibility Requirements & Terms and Conditions of the Program and that I am eligible to receive out-of-pocket assistance from the Program on the request I am submitting for cost support. I certify that I do not have government health insurance (ie, Medicare, Medicaid, VA, DoD, or other federal or state assistance programs), and that I have paid my healthcare provider for my share of the cost of administering treatment with RADICAVA®, as determined by my commercial health insurance company. I understand that I am responsible for reporting receipt of Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the treatment cost paid for by the Program, as may be required. I authorize the release of any medical information to third parties working on behalf of Mitsubishi Tanabe Pharma America, Inc. necessary to process this request for Program assistance.

Patient Name _____

Signature _____ Date _____

If you have any questions about the Program, please call 1-844-772-4548, Monday-Friday, 8:00 AM-8:00 PM ET.

This Form may only be completed by the patient or the patient's Legal Representative. This form must be submitted, along with all required documentation, for the patient to receive cost support from the Program for the applicable out-of-pocket amounts the patient has already paid to his or her infusion provider for administering RADICAVA® infusion, consistent with the Eligibility Requirements & Terms and Conditions of the Program, which can be found in the Program brochure or online at radicava.com. The patient is responsible for any amounts not covered by the Program.

See full Eligibility Requirements & Terms and Conditions available at radicava.com.

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