JourneyMate SUPPORT PROGRAM™ 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

**This form is only for use by patients treated with RADICAVA® IV.** 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.

If you are eligible for and enrolled in the Out-of-Pocket Assistance Program, you may receive a check for reimbursement of your applicable out-of-pocket costs for your medication and your infusion costs for RADICAVA® IV, or associated with the purchase/acquisition of RADICAVA® IV. 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 for RADICAVA® IV:**

1. **Complete Sections A, B, and C, and sign and date Section D:**
   - You will need your personalized 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® IV or healthcare procedure (HCPCS) code
     - Amount patient paid for RADICAVA® IV 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® IV (eg, credit card receipt, photocopy of cleared check)
3. **Send the Request for Out-of-Pocket Assistance Reimbursement 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 Out-of-Pocket Assistance Program and that MTPA has deemed me eligible to receive out-of-pocket assistance from the Program for this request for cost support. I certify that I will not seek reimbursement or compensation from any third-party account or fund including from a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA). I certify that I am not enrolled in any government health insurance other than Medicare Part A (ie, Medicare Parts B, C, or D, Medicaid, VA, DoD, or any other federal or state health insurance program), and that I have paid my healthcare provider for my share of the cost of administering treatment with RADICAVA® IV, as determined by my commercial health insurance company. I understand that I am responsible for reporting receipt of Out-of-Pocket Assistance 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 Out-of-Pocket Assistance 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 Out-of-Pocket Assistance Program assistance.

Patient Name _____

Signature _____ Date _____

**If you have any questions about the Out-of-Pocket Assistance 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 Out-of-Pocket Assistance Program for the applicable out-of-pocket amounts the patient has already paid to his or her infusion provider for administering RADICAVA® IV infusion, consistent with the Eligibility Requirements & Terms and Conditions of the Out-of-Pocket Assistance Program, which can be found in the Out-of-Pocket Assistance Program brochure or online at radicava.com. The patient is responsible for any amounts not covered by the Out-of-Pocket Assistance Program. See full Eligibility Requirements & Terms and Conditions available at radicava.com.

**Please see full Prescribing Information, including Patient Information, available at radicava.com.**


Mitsubishi Tanabe Pharma America, Inc.
525 Washington Boulevard, Suite 1100
Jersey City, NJ 07310


Mitsubishi Tanabe Pharma America