DATROWAY® (datopotamab deruxtecan-dlnk)
Patient Savings4U Program Check Request Form

INSTRUCTIONS

1. Complete all required fields
2. Print the form
3. Obtain patient signature
4. Fax the following to 1-800-887-5868
   - ☐ Completed form
   - ☐ Explanation of Benefits (EOB)
   - ☐ CMS1500 Form
   - ☐ Itemized physician receipt

The EOB provided must include the name of the insurance company, date of service, product name/J-code, and patient responsibility amount.

1-855-DATRO4U (1-855-328-7648)

Please check 1 box:

☐ Patient (check will be made payable to patient and mailed to address indicated below)

☐ Practice/Physician (check will be made payable to practice and mailed to address indicated below)

PATIENT INFORMATION

Patient Name: _____

Patient Address: _____

Patient Phone: _____ Date of Service: ___/___/___ MM/DD/YYYY

DATROWAY Card ID: _____ Amount Requested: $ _____

Physician Name: _____ Physician Phone: _____

This section should only be completed if the check is being mailed to a physician or practice.

Physician or Practice Name: _____

Address: _____

Patient Signature (or Authorized Representative): _____ Date: ___/___/___ MM/DD/YYYY

DATROWAY® (datopotamab deruxtecan-dlnk) Patient Savings4U Program Check Request Form (cont'd)

TERMS AND CONDITIONS

1. This offer is valid for commercially insured patients. Uninsured and cash-paying patients are **NOT** eligible for this Program. **2.** Eligible patients with a valid prescription of Datroway may pay as little as $0 per infusion and $0 out-of-pocket costs for Datroway, up to $26,000 per calendar year. The out-of-pocket costs covered by the program can include the product cost itself, the cost of infusion of the product (program maximum $100 per infusion assistance. **3.** This offer is not valid for patients enrolled in Medicare Part B or Medicare Part D, 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.** An explanation of benefits (EOB) statement must be faxed, uploaded in the portal, or mailed in prior to transacting on the account numbers for co-pay assistance. **5.** Offer is invalid for claims or transactions more than 180 days from the date on the EOB. **6.** Patients will be automatically re-enrolled in the next calendar year. **7.** Patient will become inactive after 18 months if there is no claim activity. **8.** Daiichi Sankyo, Inc. reserves the right to rescind, revoke or amend this offer without notice. Offer good only in the USA, including Puerto Rico, at participating pharmacies or healthcare providers. **9.** Void if prohibited by law, taxed, or restricted. **10.** This account number is not transferable. The selling, purchasing, trading, or counterfeiting of this account number is prohibited by law. **11.** This account number is not insurance. **12.** 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.

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