Reimbursement Request Form
Evrysdi Co-pay Program

P.O Box 2106, Morristown, NJ 07962

Phone: (800) 636-0316
Fax: (866) 796-1448
www.Evrysdicopay.com

Patient Name:_______________________________________Date of Birth: ______________

Legally Authorized Person Name *(if applicable)*: ____

Provider Name: ____

Evrysdi Co-pay Program Member ID:___________________Drug Name: __________________

(Located on your Welcome Letter or at www.Evrysdicopay.com)

Reimbursement Payable to: □ Patient □ Legally Authorized Person □ Provider*

Name:____

Address:____

City/State/ZIP:____

Amount Requested: ____

**If a provider completes the form, the Patient Attestation does not need to be signed.*

Patient Attestation and Signature

I attest that I have commercial insurance, an on-label prescription for Evrysdi and will not seek reimbursement from my health insurance or other patient assistance programs. I also certify that, to the best of my knowledge, the information on this reimbursement request form is true and correct.

Patient or Legally
Authorized Person Signature: ____

Date: ____

Please fax the completed form along with the patient's detailed Explanation of Benefits (EOB) to the fax number above or mail to the address above.

A detailed EOB includes insurance carrier name and logo, name of the plan, patient's responsibility, date of service and drug code broken out by name, J-code or National Drug Code (NDC). For reimbursement to patient, a copy of the paid receipt must also accompany the above.

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