RemiStart® Extended Access Program for REMICADE® (infliximab)

6501 Weston Parkway, Suite 370, Cary, NC 27513 Phone: 888-ACCESS1 (888-222-3771) Fax: 877-234-3048
www.RemiStart.com

<Current Date>

Dear Physician or Office Manager,

This form is being sent to you because the Explanation of Benefits (EOB) for _____, DOB _____ does not indicate that he/she received
(Patient Name) *(Date of Birth)*

REMICADE® (i.e., REMICADE®, J1745, Infliximab) at your site on _____. In order to calculate the patient's rebate as part of the RemiStart® Extended Access Program, we require clarification from you on the following information:

_____ Date of Infusion

_____ Number of Vials of REMICADE® Administered

By signing below, you are confirming that the patient received an infusion with REMICADE® of the number of vials you indicated on the date listed above.

_____

Name: _____

Please fax this form back to 1-877-234-3048 as soon as possible to ensure that this patient receives their rebate promptly.

If you have any questions about this request or the RemiStart® Extended Access Program, please call AccessOne® at 1-(888) ACCESS-1 (222-3771) or visit www.RemiStart.com.

Before prescribing REMICADE®, please see full Prescribing Information, including Boxed Warnings, Contraindications, Warnings and Precautions, Adverse Reactions, and Medication Guide available at www.REMICADE.com.

Sincerely,

RemiStart® Extended Access Program Manager

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