EISAI ASSISTANCE PROGRAM FOR BANZEL® (rufinamide) Patient Enrollment Form

PHONE: 1-855-347-2448 (1-855-EISAI-4U) Monday through Friday 8 AM – 5 PM ET | FAX: 1-888-668-8136

Please complete all sections in this form and fax to 1-888-668-8136. Incomplete information may cause a delay in processing.

PHYSICIAN INFORMATION

Physician Name: _____ Facility Name: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Office Contact Name: _____ Office Contact Phone: (____) ____-_____

Office Phone: (____) ____-_____ Office Fax: (____) ____-_____ Tax ID#: _____ NPI #: _____

Email: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Date of Birth: ___/___/_____ SSN: XXX-XX-_____ Gender: ❒ Male ❒ Female Home Phone: (____) ____-_____ Mobile Phone: (____) ____-_____

Advocate Contact Name: _____ Advocate Contact Phone: (____) ____-_____

Primary Language: _____ ❒ Patient Demographic Sheet Attached

PATIENT INSURANCE INFORMATION *(PLEASE INCLUDE FRONT AND BACK COPIES OF EACH INSURANCE CARD)*

Medical Insurance Name: _____ Insurance Plan Phone: (____) ____-_____

Member ID #: _____ Group #: _____ Policyholder Name: _____

Relationship to Patient: _____ Policyholder Date of Birth: ___/___/_____

Pharmacy Benefit Manager (PBM) Name: _____ PBM Phone: (____) ____-_____

Rx Policy #: _____ Rx Group #: _____ Rx BIN #: _____ Rx PCN #: _____

❒ Patient has multiple Rx plans ❒ Copies of Insurance Cards attached

PATIENT DIAGNOSIS INFORMATION

Diagnosis: _____ ICD-10 Code: _____

PRESCRIPTION INFORMATION

BANZEL® (rufinamide): ❒ 200mg ❒ 400mg ❒ 40mg/mL Quantity: _____ SIG: _____

PHYSICIAN DECLARATION *(NO SIGNATURE STAMPS, PLEASE)*

I verify that the above information is complete and accurate to the best of my knowledge and that I have prescribed BANZEL® (rufinamide) based on my professional judgment of medical necessity. I authorize the Eisai Assistance Program to perform an assessment of insurance verification for the above-named patient, and I further authorize and request that the Eisai Assistance Program provide to me any and all information necessary for completing a Prior Authorization or Letter of Medical Necessity, as may be required as a result of such insurance verification assessment.

Licensed Practitioner Signature: _____ Date: ___/___/_____

PATIENT AUTHORIZATION FOR HEALTH INFORMATION AND DISCLOSURE

Please be sure the applicant signs and dates as indicated. This enrollment cannot be processed without the applicant's signature.

I hereby authorize my health care providers and health insurer(s) to disclose to Eisai Inc., its National Account Reimbursement Managers, and other Eisai employees, agents, and service providers involved in the Eisai Assistance Program (collectively the "Assistance Group") any personal health information ("PHI") about me that is relevant to my treatment with Eisai's drug BANZEL® (rufinamide) capsules so that the Assistance Group may assist me with benefits support in connection with such treatment. The Assistance Group may use my PHI, for example, to communicate with me regarding such treatment and my treatment options, to investigate my insurance coverage, and otherwise help coordinate and assist with treatment support. I understand that once my PHI is disclosed pursuant to this authorization, it may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the Eisai Assistance Program intends to safeguard my PHI and to use and disclose it only for the purposes described herein. TrialCard may receive compensation from Eisai for certain services, including the collection and provision of data. I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits and that I may cancel the Authorization at any time by sending a written notice of cancellation to the Eisai Assistance Program either by mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, or by fax to 1-888-668-8136. If I do not cancel it, the Authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this Authorization when it is signed.

Patient or Legal Guardian Signature: _____ Date: ___/___/_____

Eisai cannot guarantee payment of any claim. Coding, coverage, and reimbursement may vary significantly by payer, plan, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. For additional information, customers should consult with their payers for all relevant coding, reimbursement, and coverage requirements. It is the sole responsibility of the provider to select the proper code and ensure the accuracy of all claims used in seeking reimbursement. All services must be medically appropriate and properly supported in the patient medical record.

Eisai