THE EISAI ASSISTANCE PROGRAM

Eisai Assistance Program
INSURANCE VERIFICATION FORM
Please fax completed form to 844-375-4063

Phone: 866-61-EISAI (866-613-4724)

INSTRUCTIONS

1. **Complete all sections of this form for Insurance Verification**
2. **Fax completed form to 844-375-4063**

DRUG/DIAGNOSIS INFORMATION (Required)

Eisai Drug Requested: ❐ BELVIQ XR® (lorcaserin hydrocloride) CIV extended-release tablets ❐ BELVIQ® (lorcaserin hydrochloride) CIV tablets

Diagnosis: ______________________________ Diagnosis Code(s): ______________________________

PATIENT INFORMATION (Please print)

Social Security #: **XXX-XX-** ______________________ Phone: ______________________

Patient Name: ______________________ Date of Birth: ____/____/____ Gender: M ❐ F ❐

Address: ______________________ City: ______________ State: _____ ZIP: __________

DIAGNOSIS/MEDICAL INFORMATION Required (Must be completed by a healthcare professional)

Diagnosis: Please provide the primary diagnosis code and supplementary classification codes that apply.

❐ ______________ ❐ ______________

Diagnosis: Please include any secondary diagnosis code and supplementary classification codes that apply.

❐ ______________ ❐ ______________ ❐ ______________

Current patient weight: ______________ Height: ______________ Current patient BMI: ______________

Does patient currently have any of the following: ❐ Concurrent use of other weight-loss products ❐ Pregnancy

Has patient previously received prescription weight management medication? If so, which one: ______________

If a refill prescription, the amount of patient weight loss within past 12 weeks: ______________

Additional medical justification for use (i.e. include prior behavior modification attempts such as diet and exercise): ______________

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INSURANCE INFORMATION (Attach a copy of the front & back of patient insurance card, prescription drug card, Medicare and/or Medicaid cards)

PRIMARY COVERAGE		SECONDARY COVERAGE	
Insurance Name:		Insurance Name:	
Insurance Phone #:		Insurance Phone #:	
Policy #:		Policy #:	
Group #:		Group #:	
Policy Holder's Name:		Policy Holder's Name:	
Policy Holder's DOB:		Policy Holder's DOB:	
Policy Holder's SSN:	**XXX-XX-**	Policy Holder's SSN:	**XXX-XX-**
Employer:		Employer:	
Employer #:		Employer #:	
Rx Policy #:		BIN #:	
Rx Group #:		PCN #:	

PHYSICIAN/FACILITY INFORMATION (Please print and ensure all ID#s correspond to the GROUP or PROVIDER)

Physician Name: ______________________ NPI #: ______________

Facility Name: ____

Address: ______________________ City: ______________ State: _____ ZIP: __________

Phone: ______________ Fax: ______________ Office Contact: ______________

DEA #: ______________ Tax ID: ______________ State License No: ______________

PHYSICIAN CERTIFICATION

Please indicate that you agree to these terms by signing below. Failure to comply with these terms may mean you (and any patients you treat) will not be eligible to participate in the Eisai Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician's 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.

PATIENT AUTHORIZATION FOR HEALTH INFORMATION USE AND DISCLOSURE

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 BELVIQ® or BELVIQ XR® , 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 redisclosed 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.

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 1981 Marcus Ave Ste 225, New Hyde Park, NY 11042 or by fax to 844-375-4063. 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.

______________________	______________________	__________
[Name of Patient]	Signature	Date
______________________	______________________	__________
[Name of Legal Representative]	Signature	Date

If signed by legal representative, describe the nature of his/her relationship with patient:

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