EISAI ASSISTANCE PROGRAM FOR FYCOMPA® (perampanel) CIII — 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

FYCOMPA® (perampanel) CIII: **Tablet**: ❒ 2mg ❒ 4mg ❒ 6mg ❒ 8mg ❒ 10mg ❒ 12mg **Liquid**: ❒ 4mL ❒ 8mL ❒ 12mL ❒ 16mL ❒ 20mL ❒ 24mL

Quantity: _______ SIG: ______________ Is this a dosage increase? ❒ Yes ❒ No

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 FYCOMPA 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: ____/____/_______

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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 FYCOMPA® 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: ____/____/________

FYCOMPA PATIENT ASSISTANCE *(COMPLETION OF THIS SECTION IS ONLY REQUIRED FOR CONSIDERATION OF FYCOMPA PATIENT ASSISTANCE)*

1. Is the patient a U.S. resident? ❒ Yes ❒ No
2. Annual household income: $ ___________ **Please Attach Documentation†**
3. How many people, including the patient, live in the household? ___________
4. Is the patient currently enrolling in Medicaid? ❒ Yes ❒ No

†Financial documentation is required for the patient to receive assistance through the FYCOMPA Patient Assistance Program. Acceptable documentation includes 1040 tax return, SSA-1099, W-2, social security benefit statement, unemployment or disability statement, or one month of paycheck stubs. Patient may be asked to provide a copy of government issued identification (e.g., driver's license, military ID, passport, etc.)

PATIENT INFORMED CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE FYCOMPA PATIENT ASSISTANCE PROGRAM

I understand that completing this form does not ensure that I will qualify for the Eisai FYCOMPA Patient Assistance Program ("Program"). I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Program if I obtain coverage through another source or if I no longer meet the income criteria for the Program. I authorize my healthcare provider to disclose medical information and related information to Eisai Inc., and its affiliated companies and subcontractors, including TrialCard (the "Program Administrator"), and I authorize Company to obtain and disclose information as deemed necessary to verify the accuracy and completeness of this application and to provide services available through the Program. I understand that personal identifying information provided on this form will be available to Company and its agents for the purpose of administering the Program. I understand that Company reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program. If I decide to terminate my authorization for my health care providers and my insurers to disclose my information to Company, I shall notify Company in writing at Eisai FYCOMPA Patient Assistance Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 that I no longer provide such authorization which termination shall be effective upon Company's receipt of such notification. I understand that I have a right to obtain a copy of the information my health care providers or insurers have provided to Company upon request to Company. I understand that I may decline to sign this form and decline being considered for the Program. I understand that signing this form does not affect the way my health care providers or insurer will provide me with their respective services.

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.

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FYCOMPA® (perampanel) CIII PATIENT ASSISTANCE PROGRAM ADDITIONAL INFORMATION

FYCOMPA PATIENT ASSISTANCE PROGRAM ELIGIBILITY

- ❒ Patient must be a US Resident
- ❒ Financial documentation is required. Acceptable forms of documentation include federal tax return, social security benefit statement, unemployment or disability statement, or one month of paycheck stubs. You may be asked to provide a copy of government issued identification (e.g., driver's license, military ID, passport, etc.)
- ❒ Household size must be indicated
- ❒ Patients insured by Medicare, Medicaid, Tricare, VA or other Federal or State healthcare plans are not eligible for patient assistance

If the patient is determined eligible for the Eisai FYCOMPA Patient Assistance Program, an acceptance letter will be mailed to the patient and faxed to the physician. If the patient is not eligible for the Eisai FYCOMPA Patient Assistance Program, a denial letter will be mailed to the patient and faxed to the physician. Enrollment in the Eisai FYCOMPA Patient Assistance Program is valid for up to one year, at which time a new enrollment form must be submitted for an eligibility determination of continued need. Completion of the Patient Enrollment Form does not guarantee enrollment into the FYCOMPA Patient Assistance Program. Please notify us of any change in patient insurance status.

PATIENT AUTHORIZATIONS

- ❒ Be sure the applicant signs and dates BOTH the Patient Authorization for Health Information and Disclosure, and the Patient Informed Consent and Authorization for Use and Disclosure of Health Information for the FYCOMPA Patient Assistance Program

Please write legibly and complete all sections to prevent delays. Forward the completed form to the fax indicated on the enrollment form, or mail to:

Eisai Assistance Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

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