THE EISAI ASSISTANCE PROGRAM

Eisai Assistance Program
INSURANCE VERIFICATION FORM
Please fax completed form to 866-57-EISAI (866-573-4724)

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

INSTRUCTIONS

1. **Complete all sections of this form for Insurance Verification**
2. **Fax completed form to 866-57-EISAI (866-573-4724)**

DRUG/DIAGNOSIS INFORMATION (Required)

Eisai Drug Requested: ❒ **ALOXI®** (palonosetron HCl) injection

Administered with: (List all agents) _____

Diagnosis: _____ Diagnosis Code(s): _____

Eisai Drug Requested: ❒ **HALAVEN®** (eribulin mesylate) injection

Please list prior therapies: _____

Diagnosis: _____ Diagnosis Code(s): _____

PATIENT INFORMATION (Please print)

U.S. Resident: ❒ Yes ❒ No Social Security #: _____ Phone: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: M ❒ F ❒

Address: _____ City: _____ State: _ ZIP: ___

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:		Policy Holder's SSN:	
Employer:		Employer:	
Employer #:		Employer #:	
Payer Specific Provider # or PTAN (if applicable)		Payer Specific Provider # or PTAN (if applicable)	

PATIENT CONSENT

The Eisai Assistance Program ("Program") requires us to confirm with you that the patient's consent provides authorization for us to obtain and provide insurance information and for us to contact the insurer and relay patient-related information, e.g., patient's name, date of birth, Social Security number, diagnosis, insurance information, etc.
Does your facility have the patient's valid written authorization on file?

❒ **Yes** *If yes, no additional authorization is needed.* ❒ **No** *If no, please have the patient sign authorization on page 2 so that you may disclose to the Program information necessary for the Program to provide and obtain information related to this reimbursement issue.*

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: _____

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: _____

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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 ALOXI® (palonosetron HCl) injection or HALAVEN® (eribulin mesylate) injection, 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.

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 Post Office Box 29231, Phoenix, AZ 85038, or by fax to 866-573-4724. 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:

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.