THE EISAI ASSISTANCE PROGRAM

Eisai Patient Assistance Program (PAP) Enrollment Form

Please complete this form and fax to: 866-57-EISAI (866-573-4724)

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

SECTION 1: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Telephone: _____ U.S. Resident: ❒ Yes ❒ No Gender: M ❒ F ❒

Social Security #: _____ OR Visa #: _____ OR Green Card #: _____

Visa/Green Card Expiration Date: _____ /_____ /_____

Address: _____ City: _____ State: _____ ZIP: _____

SECTION 2: SELECT PRODUCT AND PROVIDE STRENGTH, DOSAGE, AND QUANTITY REQUESTED

❒ **ALOXI**® (palonosetron HCl) injection

❒ **HALAVEN**® (eribulin mesylate) injection

Strength: _____ Qty: _____ Refills: _____

Dosage: _____

SECTION 3: PHYSICIAN CERTIFICATION AND SHIPPING INFORMATION

– product typically ships within 1-3 business days of patient assistance approval

Ship to: ❒ Physician ❒ Facility

Contact: _____ Phone: _____ Fax: _____

Facility Name: _____ Facility License #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Physician Name: _____ Tax ID #: _____ NPI #: _____ DEA #: _____

Physician Signature: _____ Date: _____

I certify that the information provided in this application is complete and accurate and that the product ordered hereunder is medically indicated for this patient. I further certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party shall be charged for such product. Additionally, no units of product will be submitted for Medicare, Medicaid, or any public or private third party reimbursement, or returned for credit. I understand eligibility under this Program is subject to Eisai Inc.'s approval and the patient's continuing compliance with all eligibility requirements, as set by Eisai Inc. from time to time. I agree to allow Eisai, or its authorized agent(s), to review the medical, financial and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the Program and the patient's receipt of any product(s) provided to him or her through the Program.

SECTION 4: INSURANCE INFORMATION – attach a copy of insurance cards, if available

Does the applicant have insurance? ❒ Yes ❒ No If yes, complete the table below (include all insurance policies)

Insurance Information	Check One	Policy Number	Phone Number
Private Drug Coverage	❒ Yes ❒ No		
Medicaid	❒ Yes ❒ No		
Has the patient applied for Medicaid?	❒ Yes ❒ No	If yes, date of application	
Medicare	❒ Yes ❒ No		

SECTION 5: FINANCIAL INFORMATION – financial documentation is required for the patient to receive assistance through this program

Total Household Gross Annual Income $_____

Included but not limited to Salary, Wages, Pension, Retirement, Social Security, Social Security Disability, Alimony, Child Support, Unemployment and Worker's Comp.
See instructions for acceptable forms of income documentation.

Total Current Year to Date Out of Pocket Prescription Costs $_____

Provide the amount the patient has spent year to date (January–current month).

Number of household members dependent on income stated above (including applicant): 1 2 3 4 5 6 7 8 **(circle one)**

SECTION 6: PATIENT AUTHORIZATION AND ACKNOWLEDGEMENT

Please review and sign in each place indicated on page 2.

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INSTRUCTIONS: HOW TO COMPLETE THE ENROLLMENT FORM

OVERVIEW

1. **Complete all sections of the enrollment form. Patient must sign the enrollment form in each place indicated for PAP review.**
2. **Financial documentation is required. Acceptable forms of documentation include federal tax returns, Social Security benefit statements, one month's worth of paycheck stubs, and unemployment or disability statements.**
3. **Fax the enrollment form with copies of financial documentation to 866-57-EISAI (866-573-4724).**
4. **Please note: Inpatient use of PAP product is not allowed.**

SECTION 1: PATIENT INFORMATION

❒ To qualify for the program, the patient must be a legal US Resident. Social Security, Visa, or Green Card number is required.

❒ P.O. Box addresses will not be accepted.

SECTION 2: PRODUCT, STRENGTH, DOSAGE, AND QUANTITY REQUESTED

❒ Be sure to select the product you are seeking and provide the strength, dosage, and quantity you are requesting.

SECTION 3: PHYSICIAN CERTIFICATION AND SHIPPING INFORMATION

❒ Be sure the Physician signs and dates this section. This enrollment cannot be processed without a Physician's signature.

❒ Be sure you have selected where the product should ship. If a shipping location is not selected, product shipment may be delayed.

❒ If product is being shipped to the Facility, complete all of the Facility shipping information. If the information is not complete, product shipment may be delayed.

❒ The Facility License # is required for product shipment to the Physician.

❒ Product typically ships within 1-3 business days of patient assistance approval.

SECTION 4: INSURANCE INFORMATION

❒ Attach a copy of insurance cards, if available.

SECTION 5: FINANCIAL INFORMATION

❒ Financial documentation is required. Acceptable forms of documentation include federal tax returns, Social Security benefit statements, one month's worth of paycheck stubs, and unemployment or disability statements.

❒ Out-of-pocket prescription costs may be taken into consideration when determining patient eligibility. Please include them, if applicable.

❒ Household size must be selected.

SECTION 6: PATIENT AUTHORIZATION AND ACKNOWLEDGEMENT

❒ Be sure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without a patient's signature.

SECTION 6: 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® (palonosetrom HCI) 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:

_____

PATIENT ACKNOWLEDGEMENT

I understand that completing this form does not ensure that I will qualify for the Eisai Patient Assistance Program ("PAP"). I represent that the information provided in this enrollment form is complete and accurate. I agree to notify and shall be responsible for notifying the program administrator for the PAP if I obtain coverage through another source or if I no longer meet the income criteria for the PAP. I understand that Eisai Inc. reserves the right at any time and without notice to me to modify and/or discontinue any or all of the PAP, including modification of eligibility criteria and immediate termination of assistance provided by the PAP. I understand that I may decline to sign this form and decline being considered for the PAP.

[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:

_____

Please be sure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without the patient's signatures.