LENVIMA® (lenvatinib) Eisai Assistance Program Enrollment Form

Eisai Assistance Program

This form is used to enroll in the LENVIMA Eisai Assistance Program, and to apply for the Eisai Patient Assistance Program. Patient Support includes:

Benefits investigation
- Help patients understand their coverage for LENVIMA

Patient starter kit
- Includes key LENVIMA educational materials and helpful resources for patients receiving therapy

Ongoing patient communications
- Monitors patient progress, adverse reactions, and questions about LENVIMA therapy

Patient Assistance Program
- Provides LENVIMA at no cost to eligible patients with financial need

Eisai Assistance Program
Phone: **1-866-61-EISAI (1-866-613-4724)** • Fax: **1-855-246-5192**

If dispensing LENVIMA from your office/clinic or hospital pharmacy, please select from the following patient support services to enroll. (Please check all that apply.)

- ☐ **Benefits investigation**
- ☐ **Patient starter kit**
- ☐ **Patient communications**
- ☐ **Apply for Eisai Patient Assistance Program** (subject to eligibility)

Physician information

Physician Name:_____

Facility Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Office Contact:_____

Telephone:_____

Fax:_____

Best Time to Call:_____

Email:_____

State License #:_____

Tax ID #:_____ NPI #:_____

Patient diagnosis information

Patient Name:_____

Date of Birth:____/_____/_____

Diagnosis/ICD Code:_____

Height:_____ Weight:_____

Baseline Blood Pressure:_____

Prescription

Need approval for assistance through the Eisai Assistance Program. Medication will be shipped via Specialty Pharmacy to the patient's home address unless otherwise indicated by the prescriber.

Product Name: LENVIMA capsules

Each dosage is supplied in 5-day blister cards (4-mg and/or 10-mg capsules). 6 blister cards for a 30-day supply:

Dose	Daily capsules in blister card
☐ 24 mg	10 mg, 10 mg, 4 mg
☐ 20 mg	10 mg, 10 mg
☐ 18 mg	10 mg, 4 mg, 4 mg
☐ 14 mg	10 mg, 4 mg
☐ 12 mg	4 mg, 4 mg, 4 mg
☐ 10 mg	10 mg
☐ 8 mg	4 mg, 4 mg
☐ 4 mg	4 mg

Sig:_____

Refill(s):_____

Quantity of blister cards (5-day supply per card):_____

Physician Signature:_____

Date:_____

Prescriber: Please attach a separate prescription if this section does not comply with your state's prescription law.

LENVIMA® (lenvatinib) capsules 10 mg and 4 mg

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Physician declaration

The above information is complete and accurate to the best of my knowledge. I have prescribed LENVIMA based on my independent professional judgment of medical necessity and have taken into account relevant patient safety considerations and the full prescribing information.

[Please sign the appropriate line for the selected dispensing instruction.]

Physician Signature:_____ **Date:** _____
(no stamps) (Substitution Permitted)

Physician Signature:_____ **Date:** _____
(no stamps) (Dispense as Written)

Patient information

Name:_____

Street Address:_____

City:_____

State:_____ Zip:_____Date of Birth:___ /___ /___

Gender: ☐ M or ☐ F

SSN:_____

Daytime Telephone:_____

Evening Telephone:_____

Cell Phone:_____

Best Time to Call:_____

Email:_____

Primary Language:_____

Alternative Contact Name:_____

Alternative Contact Telephone:_____

Allergies:_____

Current Medications:_____

Prescription insurance information

Primary Insurer:

Telephone:_____

Subscriber Name:_____

Date of Birth:____/_____/_____

ID #:_____

Group #:_____

BIN:_____

PCN:_____

Secondary Insurer:

Telephone:_____

Subscriber Name:_____

Date of Birth:___/_____/_____

ID #:_____

Group #:_____

BIN:_____

PCN:_____

Patient Assistance Program eligibility requirements*

Annual household income: $_____

Number of household members dependent on income (include applicant):_____

Source of income:

☐ Job ☐ Family ☐ Public Assistance ☐ SSI/SSDI

☐ Other (Please explain):_____

***Income documentation will be required in order to assess program eligibility** (eg, 1040 tax return, SSA-1099, W-2 form). Only required if applying for Patient Assistance Program.
Please see the following page for required patient authorizations.

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Patient authorization for health information and disclosure

I authorize my health care providers and health insurer(s) to disclose to Eisai Inc., its employees, agents, and service providers involved in the Eisai Assistance Program, including the Patient Assistance Program ("PAP") (collectively, the "Program") any personal health information ("PHI") about me that is relevant to my treatment with LENVIMA (lenvatinib) so the Program may assist me with financial benefits, administration and adherence support in connection with such treatment. I authorize the Program to use my PHI and to disclose it to my health care providers and health insurer(s) for the foregoing purposes. 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 Program intends to use and disclose my PHI only as 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 (other than with respect to uses and disclosures that by then have already been made in reliance on the authorization) by sending a notice of cancellation to the Eisai Assistance Program either by mail to 11800 Weston Parkway, Cary, NC 27513, or by fax to 1-855-246-5192. 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
Relation to Patient		

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Patient Assistance Program ("PAP") patient acknowledgment

I understand that completing this form does not ensure that I will qualify for PAP. I represent that the information provided in this enrollment form is complete and accurate. I agree to notify the Eisai Assistance Program if I obtain coverage through another source or if I no longer meet the income criteria for the PAP. I agree that I will not seek reimbursement for or credit from any insurer, health plan, or government program with respect to this prescription. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. 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
Relation to Patient		

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

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.