

# INTAKE FORM for LENVIMA® (lenvatinib) capsules

▶ **To receive LENVIMA through a Specialty Pharmacy and automatically enroll in all patient support services,\*** please select your preferred Specialty Pharmacy.†



Phone: **1-844-693-0156**  
Fax: **1-877-247-4847**



Phone: **1-800-850-4306**  
Fax: **1-800-823-4506**



Phone: **1-800-799-0692**  
Fax: **1-855-296-0210**

\*Patients may opt out of receiving patient support services at any time.  
†If payer requirements mandate the use of a specific Specialty Pharmacy, patient will still have his/her prescription filled.

## ▶ 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

With confirmation of insurance coverage, medication will be shipped via Specialty Pharmacy to the patient's home address unless otherwise indicated by the prescriber.

## Prescription information (cont'd)

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
<input type="checkbox"/> 24 mg	10 mg, 10 mg, 4 mg
<input type="checkbox"/> 20 mg	10 mg, 10 mg
<input type="checkbox"/> 18 mg	10 mg, 4 mg, 4 mg
<input type="checkbox"/> 14 mg	10 mg, 4 mg
<input type="checkbox"/> 12 mg	4 mg, 4 mg, 4 mg
<input type="checkbox"/> 10 mg	10 mg
<input type="checkbox"/> 8 mg	4 mg, 4 mg
<input type="checkbox"/> 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.

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



# INTAKE FORM for LENVIMA® (lenvatinib) capsules

## ► 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: \_\_\_\_\_

### **YES, my patient would be interested in the LENVIMA \$0 Co-pay Program**

(Restrictions apply. The LENVIMA \$0 Co-pay Program provides up to \$40,000 per year to assist with the out-of-pocket costs for LENVIMA. The Program is not available to patients eligible for state or federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE. Offer only available to patients with private, commercial insurance. Depending on the insurance plan, patients could have additional financial responsibility for any amounts over Eisai's maximum liability. See [www.eisaireimbursement.com](http://www.eisaireimbursement.com) for full terms/conditions.)

