INTAKE FORM for LENVIMA® (lenvatinib) capsules

Please complete this form in its entirety.

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

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

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

OR

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.)

❑ **Patient Support**
(eg, nurse support, patient starter kit)

❑ **Reimbursement assistance**
(eg, financial support, benefit investigations)

❑ **LENVIMA $0 Co-pay Program**
(for eligible patients)

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

*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

Diagnosis/ICD Code:_____
Height:_____ Weight:_____
Baseline Blood Pressure:_____

Prescription (Required ONLY if filling through Accredo or Biologics)

With confirmation of insurance coverage (or 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

Dosage/supplied in 4-mg and 10-mg capsules for 30 days as:

❑ 24 mg ❑ 20 mg ❑ 18 mg ❑ 14 mg
❑ 12 mg ❑ 10 mg ❑ 8 mg ❑ 4 mg

Sig:_____
Refill(s):_____
Quantity:_____
Date:_____

Physician declaration

I verify that the above information is complete and accurate to the best of my knowledge and that I have prescribed LENVIMA based on my independent professional judgment of medical necessity.

I authorize Eisai, Inc. and Eisai employees, agents and service providers (collectively, the "Eisai Assistance Program") to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize the Eisai Assistance Program to perform a preliminary 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 Letter of Medical Necessity, as may be required as a result of such insurance verification assessment.

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:___/___/___ 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:___/___/___ Group #:_____
ID #:_____

Secondary Insurer:_____
Telephone:_____
Subscriber Name:_____
Date of Birth:___/___/___ ID #:_____ Group #:_____

❑ **YES, my patient would be interested in the LENVIMA $0 Co-pay Program**
(Not available to patients enrolled in federal or state health care programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE.)

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).

Contact the Eisai Assistance Program by phone at 1-866-61-EISAI (1-866-613-4724) or by fax at 1-855-246-5192 for additional reimbursement support.

Please see the following page for required patient authorizations.

LENVIMA® (lenvatinib) capsules 10 mg and 4 mg

INTAKE FORM for LENVIMA® (lenvatinib) capsules

Please complete this form in its entirety.

Patient authorization for health information 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 "Eisai Assistance Program") any personal health information ("PHI") about me that is relevant to my treatment with Eisai's drug LENVIMA (lenvatinib) capsules so that the Eisai Assistance Program may assist me with benefits support in connection with such treatment. The Eisai Assistance Program 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. Agents and service providers of Eisai 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 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

If signed by legal representative, describe the nature of his/her relationship with the patient:

_____

Patient Assistance Program patient acknowledgment

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 agree that I will not seek reimbursement or credit from, or submit a claim for this prescription to any insurer, health plan, or government program. 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

If signed by legal representative, describe the nature of his/her relationship with the patient:

_____

Please be sure the applicant signs and dates this page 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.