

SECTION 1: PATIENT INFORMATION

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

Intended Product Use: Inpatient Outpatient

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

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

SECTION 2: PRESCRIPTION & PHYSICIAN CERTIFICATION – physician signature and date required. New York or New Jersey Prescribers, please use an original State Prescription Form. Quantity maximum per fill is 30 days

Halaven™ Aloxi® Dacogen® Ontak® Hexalen® Targretin® gel Targretin® capsules Panretin® Gliadel®

Strength: _____ Qty: _____ Refills: _____

Known Allergies? No Yes, please specify: _____ Other Medications Currently Taking: _____

SIG Directions: _____

Physician's Signature (required for processing): _____ **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 3: PHYSICIAN INFORMATION

Physician Name: _____ NPI #: _____ DEA # or State License #: _____

Facility Name: _____ Tax ID # _____

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

Phone: _____ Fax: _____ Office Contact: _____

SECTION 4: SHIPPING INFORMATION - product typically ships within 1-3 business days of patient assistance approval

Ship to: Physician Facility Patient (only applicable for Hexalen®, Panretin® or Targretin®) If shipping to a Facility, please provide the following information:

Contact: _____ Phone: _____ Fax: _____

Facility Name: _____ Facility DEA # or State License #: _____

Address: _____ City: _____ State: _____ Zip: _____

SECTION 5: 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	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicare Part D	<input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 6: FINANCIAL INFORMATION - financial documentation may be required for the patient to receive assistance through this program


Total Household Gross Monthly Income \$ _____ Total Current Year to Date Out of Pocket Prescription Costs \$ _____

Included but not limited to Salary, Wages, Pension, Retirement, Social Security, Social Security Disability, Alimony, Child Support, Unemployment and Worker's Comp. 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 7: APPLICANT DECLARATION

Informed Consent and Authorization for Use and Disclosure of Health Information for Patient Assistance Program
 I understand that completing this form does not ensure that I will qualify for the Eisai Assistance Program ("Program"). I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Program if I obtain coverage through another source or if I no longer meet the income criteria for the Program. I authorize my healthcare provider to disclose medical information and related information to Eisai Inc., and its affiliated companies and subcontractors (collectively "Company"), including McKesson Specialty Arizona Inc. (the "Program Administrator") and US Bioservices Corporation on behalf of itself and its subsidiaries and its affiliate, Integrated Commercialization Solutions, Inc. (together, "US Bioservices"), and I authorize Company to obtain and disclose information as deemed necessary to verify the accuracy and completeness of this application and to provide services available through the Program. I also authorize Company to release medical information and related information to the Centers for Medicare and Medicaid Services ("CMS") for purposes of administering the Program. I understand that personal identifying information provided on this form will be available to Company and its agents for the purpose of administering the Program. I understand that Company reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program. If I decide to terminate my authorization for my health care providers and my insurers to disclose my information to Company, I shall notify Company in writing at Eisai Assistance Program, Post Office Box 29231, Phoenix, AZ 85038 that I no longer provide such authorization which termination shall be effective upon Company's receipt of such notification. I understand that I have a right to obtain a copy of the information my health care providers or insurers have provided to Company upon request to Company. I understand that I may decline to sign this form and decline being considered for the Program. I understand that signing this form does not affect the way my health care providers or insurer will provide me with their respective services.

 _____ **Signature of Patient or Patient Representative** _____ **Date** _____

Printed Name of Patient OR Legal Representative (If signed by representative, explain authority to act on behalf of patient) Relationship to Patient