

PHONE: 866-349-3026 Monday through Friday 8 AM to 8 PM ET | FAX: 844-737-3493

Please complete all sections in this form and fax to 844-737-3493. Incomplete information may cause a delay in processing.

PHYSICIAN INFORMATION

Physician Name: _____ Facility Name: _____
 Street Address: _____ City: _____ State: _____ ZIP Code: _____
 Office Contact Name: _____ Office Contact Phone: (____) ____ - _____
 Office Phone: (____) ____ - _____ Office Fax: (____) ____ - _____ Tax ID#: _____ NPI #: _____
 Email: _____ DEA#: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____
 Street Address: _____ City: _____ State: _____ ZIP Code: _____
 Date of Birth: ____/____/____ SSN: _____ Gender: Male Female Home Phone: (____) ____ - _____ Mobile Phone: (____) ____ - _____
 Advocate Contact Name: _____ Advocate Contact Phone: (____) ____ - _____
 Primary Language: _____ Email: _____

PATIENT INSURANCE INFORMATION (PLEASE INCLUDE FRONT AND BACK COPIES OF EACH INSURANCE CARD OR COMPLETE THIS SECTION)

For Commercially Insured Patients

Medical Insurance Name: _____ Insurance Plan Phone: (____) ____ - _____
 Member ID #: _____ Group #: _____ Policyholder Name: _____
 Relationship to Patient: _____ Policyholder Date of Birth: ____/____/____
 Pharmacy Benefit Manager (PBM) Name: _____ PBM Phone: (____) ____ - _____
 Rx Policy #: _____ Rx Group #: _____ Rx BIN #: _____ Rx PCN #: _____
 Patient has multiple Rx plans Copies of Insurance Cards attached

For Patients Enrolled in Medicare Part D

Medical Insurance Name: _____ Insurance Plan Fax: (____) ____ - _____
 Member ID #: _____ Rx BIN #: _____ Rx PCN #: _____

PATIENT DIAGNOSIS INFORMATION

Diagnosis: _____ ICD-10 Code: _____

MEDICATIONS AVAILABLE

DAYVIGO (lemborexant) CIV: Tablet: 5mg 10mg

PRESCRIPTION INFORMATION

Product Requested: _____ Strength: _____ Quantity: _____ Refills: _____
 Directions: _____ Is this a dosage increase? _____
 Allergies: _____ Concurrent Medications: _____

Prescriber: Prescriptions should be conveyed in accordance with state laws including specific forms, e-prescribing, and quantity limitations.
 This form should not be utilized if non-conforming to regulations in your state.

Physician signature required on next page ►

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PHYSICIAN DECLARATION (NO SIGNATURE STAMPS, PLEASE)

STOP

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

Signature
Required for
Enrollment ▶

Licensed Practitioner Signature: _____ Date: ____/____/____

STOP

DAYVIGO PATIENT ASSISTANCE PROGRAM (COMPLETE THIS SECTION TO ENROLL INTO THE DAYVIGO PATIENT ASSISTANCE PROGRAM)

To Enroll in the DAYVIGO Patient Assistance Program please check here and complete this section

1. Is the patient a U.S. resident? Yes No

2. Annual household income: \$ _____

3. How many people, including the patient, live in the household? _____

4. Is the patient currently enrolling in Medicaid? Yes No

5. Is the patient uninsured or functionally uninsured? Yes No

(Patients may be functionally uninsured when their insurance doesn't cover their medication or high deductibles make their medication difficult to afford)

DAYVIGO (LEMBorexant) CIV PATIENT ASSISTANCE PROGRAM ADDITIONAL INFORMATION

DAYVIGO PATIENT ASSISTANCE PROGRAM ELIGIBILITY

Patient must be a US Resident

Household size must be indicated

Patients insured by Medicaid, Tricare, VA or other Federal or State healthcare plans are not eligible for patient assistance

If the patient is determined eligible for the DAYVIGO Patient Assistance Program, an acceptance letter will be faxed to the physician. If the patient is not eligible for the DAYVIGO Patient Assistance Program, a denial letter will be faxed to the physician. Enrollment in the DAYVIGO Patient Assistance Program is valid for up to one year, at which time a new enrollment form must be submitted for an eligibility determination of continued need. Completion of the Patient Enrollment Form does not guarantee enrollment into the DAYVIGO Patient Assistance Program. Please notify us of any change in patient insurance status.

PATIENT AUTHORIZATIONS

Be sure the applicant signs and dates BOTH the Patient Authorization for Health Information and Disclosure, and the Patient Assistance Program Acknowledgment

Please write legibly and complete all sections to prevent delays. Fax the completed form to 844-737-3493.

PATIENT ASSISTANCE PROGRAM ACKNOWLEDGMENT

STOP

I understand that completing this form does not ensure that I will qualify for the DAYVIGO Patient Assistance Program. I represent that the information provided in this enrollment form is complete and accurate. I agree to notify the DAYVIGO Patient 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. 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.

If Enrolling in
PAP, Please
Sign Here ▶

Patient or Legal Guardian Signature: _____ Date: ____/____/____

STOP

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PATIENT AUTHORIZATION FOR HEALTH INFORMATION AND DISCLOSURE

Please be sure the applicant signs and dates as indicated. This enrollment cannot be processed without the applicant's signature.

I authorize my health care providers and health insurer(s) to disclose to Eisai Inc., its employees, agents, and service providers involved in the DAYVIGO Patient Assistance Program, (collectively, the "Program") any personal health information ("PHI") about me that is relevant to my treatment with DAYVIGO so the Program may assist me with the patient assistance program 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 DAYVIGO Patient Assistance Program by fax to 844-737-3493. 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.

STOP

Signature Required for Enrollment ▼

STOP

Name of Patient: _____ Signature: _____ Date: ____/____/____

Name of Legal Representative: _____ Signature: _____ Date: ____/____/____

Relation to Patient: _____