Specialty Pharmacies

To receive LENVIMA through a Specialty Pharmacy and to enroll in patient support,* please complete this form and submit it to your preferred Specialty Pharmacy.† Visit www.LenvimaSpecialtyPharmacy.com for the list of authorized Specialty Pharmacies that are available to dispense LENVIMA.

*Patients may opt out of receiving patient support 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	**Site/Facility Name**		
Street Address	**City**	**State**	**Zip**
Office Contact	**Telephone Number**		
Fax	**Office Email**		
State License #	**Tax ID #**	**NPI #**	

Patient Information

Patient Name		**Date of Birth**	**Gender** ☐ M ☐ F	**SSN**
Street Address		**City**	**State**	**Zip**
Patient Phone Number	**Cell Phone Number**	**Email**		**Primary Language**
Alternate Contact Name	**Relationship to Patient**	**Alternate Contact Telephone**		
Allergies		**Current Medications**		

Patient Diagnosis Information

Diagnosis/ICD Code		
Height	**Weight**	**Baseline Blood Pressure**

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

❑ **YES, my patient would be interested in the LENVIMA $0 Co-Pay Program**

With the LENVIMA $0 Co-Pay Program, eligible commercially insured patients will pay as little as $0 out-of-pocket for each prescription. Eisai will pay up to a maximum of $40,000 per year to assist with the out-of-pocket costs for LENVIMA.‡

‡**Maximum benefit and eligibility:** Depending on the insurance plan, patients could have additional financial responsibility for any amounts over Eisai's maximum liability. **Not available to patients enrolled in state or federal health care programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE.** Offer only available to patients with private, commercial insurance. See www.LENVIMAREIMBURSEMENT.com for complete terms and conditions.

LENVIMA® (lenvatinib) capsules 10 mg and 4 mg

Patient Information

Patient Name	Date of Birth

Patient Insurance Information

1	**Primary Medical Insurance**	**Telephone Number**	**Policy ID #**
	BIN	**PCN**	**Group #**
	Policyholder Name		**Policyholder Date of Birth**
2	**Secondary Medical Insurance**	**Telephone Number**	**Policy ID #**
	BIN	**PCN**	**Group #**
	Policyholder Name		**Policyholder Date of Birth**

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.

Medication Name: LENVIMA capsules **Medication Dose*†:** _____

Dose	Daily Capsules in Blister Card	Quantity for 30 Days Supply
24 mg	10 mg, 10 mg, 4 mg	**#60** caps of 10 mg; **#30** caps of 4 mg
20 mg	10 mg, 10 mg	**#60** caps of 10 mg
18 mg	10 mg, 4 mg, 4 mg	**#30** caps of 10 mg; **#60** caps of 4 mg
14 mg	10 mg, 4 mg	**#30** caps of 10 mg; **#30** caps of 4 mg
12 mg	4 mg, 4 mg, 4 mg	**#90** caps of 4 mg
10 mg	10 mg	**#30** caps of 10 mg
8 mg	4 mg, 4 mg	**#60** caps of 4 mg
4 mg	4 mg	**#30** caps of 4 mg

*LENVIMA is available in 4 mg and 10 mg capsules.
†LENVIMA capsules are supplied in cartons of 6 cards. Each card is a 5-day blister card.

Sig: _____

Quantity: _____ **Refills:** _____

Physician Signature: _____ **Date:** _____

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

Physician Declaration

The provided 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.

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