LENVIMA® (lenvatinib) capsules | 10 mg and 4 mg

Eisai Patient Support

Specialty Pharmacy Intake Form

Phone: 1-866-61EISAI (1-866-613-4724)
Fax: 1-855-246-5192
Monday–Friday: 8 AM–8 PM ET

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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 their 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**

☐ **YES, my patient would be interested in the LENVIMA Co-pay Program**

With the LENVIMA Co-pay Program, eligible commercially insured patients may pay as little as $0 per month. Annual limits apply.‡

‡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 healthcare 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.

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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-Day 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)

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