EISAI ASSISTANCE PROGRAM FOR BANZEL® (rufinamide)

Patient Enrollment Form

PHONE: 1-855-347-2448 (1-855-EISAI-4U) Monday through Friday 8 AM – 5 PM ET | FAX: 1-888-668-8136

Please complete all sections in this form and fax to 1-888-668-8136. 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: ______________________

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Street Address: ______________________ City: ______________ State: _______ ZIP Code: ___________

Date of Birth: ___/___/_______ SSN: XXX-XX-_______ Gender: ❒ Male ❒ Female Home Phone: (____) ____-___________ Mobile Phone: (____) ____-___________

Advocate Contact Name: ______________________ Advocate Contact Phone: (____) ____-___________

Primary Language: ______________________ ❒ Patient Demographic Sheet Attached

PATIENT INSURANCE INFORMATION (PLEASE INCLUDE FRONT AND BACK COPIES OF EACH INSURANCE CARD)

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

PATIENT DIAGNOSIS INFORMATION

Diagnosis: ______________________ ICD-10 Code: ______________________

PRESCRIPTION INFORMATION

BANZEL® (rufinamide): ❒ 200mg ❒ 400mg ❒ 40mg/mL Quantity: _______ SIG: ______________________

PHYSICIAN DECLARATION (NO SIGNATURE STAMPS, PLEASE)

I verify that the above information is complete and accurate to the best of my knowledge and that I have prescribed BANZEL® (rufinamide) based on my professional judgment of medical necessity. I authorize the Eisai Assistance Program to perform an 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 Prior Authorization or Letter of Medical Necessity, as may be required as a result of such insurance verification assessment.

Licensed Practitioner Signature: ______________________ Date: ____/____/_________

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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 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 "Assistance Group") any personal health information ("PHI") about me that is relevant to my treatment with Eisai's drug BANZEL® (rufinamide) capsules so that the Assistance Group may assist me with benefits support in connection with such treatment. The Assistance Group 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. TrialCard 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 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, or by fax to 1-888-668-8136. 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	Patient Signature	Date
Name of Legal Representative	Legal Representative Signature	Date
Relation to Patient		

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.