# EISAI ASSISTANCE PROGRAM FOR FYCOMPA® (perampanel) CIII

**Patient Enrollment Form**

**PHONE: 1-855-347-2448 (1-855-EISAI-4U) Monday through Friday 8 AM – 5 PM ET | FAX: 1-844-633-8444**

***Please complete all sections in this form and fax to 1-844-633-8444. Incomplete information may cause a delay in processing.***

❒ **For assistance with benefit investigation, prior authorization and appeals assistance check here**

❒ **For assistance with the patient assistance program please check here**

## 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: XXX-XX-________ 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)*

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: ______________________

## MEDICATIONS AVAILABLE

FYCOMPA® (perampanel) CIII: **Tablet**: 2mg 4mg 6mg 8mg 10mg 12mg **Liquid**: 4mL 8mL 12mL 16mL 20mL 24mL

## PRESCRIPTION INFORMATION

Product Requested: ______________________ Strength: ______________ Quantity: ______________ Refills: ______________
Frequency/Directions: ______________________ SIG: ______________________ Is this a dosage increase? __________
Allergies: ______________________
Concurrent Medications: ______________________

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



Eisai

## EISAI ASSISTANCE PROGRAM FOR FYCOMPA® (perampanel) CIII — Patient Enrollment Form

**PHONE: 1-855-347-2448 (1-855-EISAI-4U) Monday through Friday 8 AM – 5 PM ET I FAX: 1-844-633-8444**

***Please complete all sections in this form and fax to 1-844-633-8444. Incomplete information may cause a delay in processing.***

### PHYSICIAN DECLARATION *(NO SIGNATURE STAMPS, PLEASE)*

STOP

Signature Required for Enrollment ▶

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

STOP

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

### 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 Eisai Assistance Program, including the Patient Assistance Program ("PAP") (collectively, the "Program") any personal health information ("PHI") about me that is relevant to my treatment with FYCOMPA so the Program may assist me with financial benefits, administration and adherence support 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 Eisai Assistance Program either by mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, or by fax to 1-844-633-8444. 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: ______________________________

### FYCOMPA PATIENT ASSISTANCE *(COMPLETION OF THIS SECTION IS ONLY REQUIRED FOR ENROLLMENT INTO THE FYCOMPA PATIENT ASSISTANCE PROGRAM)*

❒ **To Enroll in the Fycompa Patient Assistance Program please check here and complete this section**

1. Is the patient a U.S. resident? ❒ Yes ❒ No
2. Annual household income: $ ____________ **Please Attach Documentation†**
3. How many people, including the patient, live in the household? ____________
4. Is the patient currently enrolling in Medicaid? ❒ Yes ❒ No

**†Financial documentation is required for the patient to receive assistance through the FYCOMPA Patient Assistance Program. Acceptable documentation includes 1040 tax return, SSA-1099, W-2, social security benefit statement, unemployment or disability statement, or one month of paycheck stubs. Patient may be asked to provide a copy of government issued identification (e.g., driver's license, military ID, passport, etc.)**



Eisai

**PHONE: 1-855-347-2448 (1-855-EISAI-4U) Monday through Friday 8 AM – 5 PM ET I FAX: 1-844-633-8444**

***Please complete all sections in this form and fax to 1-844-633-8444. Incomplete information may cause a delay in processing.***

## PATIENT ASSISTANCE PROGRAM ACKNOWLEDGMENT

**STOP**

If Enrolling in PAP, Please Sign Here ▶

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

**STOP**

Patient or Legal Guardian Signature: ______________________________ Date: ____ /____ /_________

## FYCOMPA® (perampanel) CIII PATIENT ASSISTANCE PROGRAM ADDITIONAL INFORMATION

**FYCOMPA PATIENT ASSISTANCE PROGRAM ELIGIBILITY**

❐ Patient must be a US Resident

❐ Financial documentation is required. Acceptable forms of documentation include federal tax return, social security benefit statement, unemployment or disability statement, or one month of paycheck stubs. You may be asked to provide a copy of government issued identification (e.g., driver's license, military ID, passport, etc.)

❐ Household size must be indicated

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

If the patient is determined eligible for the Eisai FYCOMPA Patient Assistance Program, an acceptance letter will be mailed to the patient and faxed to the physician. If the patient is not eligible for the Eisai FYCOMPA Patient Assistance Program, a denial letter will be mailed to the patient and faxed to the physician. Enrollment in the Eisai FYCOMPA 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 FYCOMPA 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. Forward the completed form to the fax indicated on the enrollment form, or mail to:

**Eisai Assistance Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**

**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.**



Eisai