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

## Eisai Assistance Program

**Please select from the following patient support services to enroll. Please check all that apply.**

☐ **Benefits Investigation**
Helps patients understand their coverage for LENVIMA

*To enroll in benefits investigation, complete pages 1, 2, and 3.*

☐ **Patient Assistance Program (PAP)**
Provides LENVIMA at no cost to eligible patients with financial need

*For patient assistance, complete this form in its entirety. Two patient signatures are required on pages 3 and 4 to process the enrollment.*

☐ **Patient Starter Kit**
Includes key LENVIMA educational materials and helpful resources for patients receiving therapy

*To receive a patient starter kit, complete pages 1 and 3. No physician signature required.*

## 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** |

## 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

Need approval for assistance through the Eisai Assistance Program. 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)

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

## Patient Authorization for Use and Disclosure of Health Information

I hereby authorize my health care providers and health insurer(s) to disclose to Eisai Inc. and 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") relevant to my treatment with LENVIMA (lenvatinib) so the Program may assist me with financial benefits, administration and adherence support regarding such treatment. I also authorize the Program to use and disclose my PHI for the foregoing purposes, including as follows: (1) disclosures to my providers and insurer(s), and any caregivers I specifically designate; (2) contact me via postal mail, email, phone or text message at the number(s) I provide (including via autodialing and/or prerecorded messages) to (i) discuss my PAP eligibility; (ii) assist me with benefits verification, prior authorizations, or insurance appeals; (iii) convey financial resources information (e.g., copay support or free drug programs); and (iv) send a patient starter kit or provide adherence support; and (3) quality assessment and improvement purposes in administering the Program. I understand that once my PHI is disclosed, it may no longer be protected by federal law and could be re-disclosed to others. I understand that I do not need to sign this authorization to receive health care treatment or insurance benefits, and that I may cancel the authorization at any time by notifying the Eisai Assistance Program either by mail to 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067, or by fax to 1-855-246-5192. However, my cancellation would not affect uses or disclosures of information that were already authorized. If I do not cancel it, the authorization will remain in effect for twenty-five years 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 | | |

## Patient Assistance Program Eligibility Requirements*

| Annual Household Income | Number of Household Members Dependent on Income *(include Applicant)* |
|---|---|
| | |

**Source of Income**

☐ Job ☐ Family ☐ Public Assistance ☐ SSI/SSDI ☐ Other (explain)_____

***Income documentation will be required in order to assess program eligibility** (eg, 1040 tax return, SSA-1099, W-2 form). Only required if applying for Patient Assistance Program.

## Patient Assistance Program ("PAP") Patient Acknowledgment

I understand that completing this form does not ensure that I will qualify for PAP. I certify 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. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. 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.

Verification of income will be required in order for EAP to assess program eligibility. By signing below, I authorize Eisai Inc. and its service providers administering the Patient Assistance Program (collectively, "Eisai") to obtain financial information from my credit profile or other financial information from Experian Income View. I understand that Eisai needs, and I agree that Eisai may use, this financial information to determine my financial eligibility to participate in Eisai's Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner, if so requested.

| 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.

LENVIMA® (lenvatinib) capsules 10 mg and 4 mg

## Patient Consent to Receive Calls and Text Messages (OPTIONAL)

By signing below, in addition to signing the Patient Authorization for Health Information Use and Disclosure on page 3 of this Eisai Assistance Program Enrollment Form, I consent to receive autodialed phone calls, calls using recorded messages, and text messages from Eisai or its service providers (as defined in the Authorization on page 3), regarding support services and other products and services that may interest me, at the telephone number(s) I have provided on this Enrollment Form or otherwise provided to the PAP. I understand that my consent to receive such calls and messages is optional and is not a condition for my purchasing any goods or services from Eisai or the PAP. I understand that message and data rates may apply and that I may opt out of receiving these calls or texts at any time, as will be indicated in each such call or text.

| Name of Patient or Patient Representative (Print) | Signature | Date |
|---|---|---|

**If signed by legal representative of patient:**

**Description of representative's relationship providing authority to sign for patient**