Halaven®
(eribulin mesylate) Injection | 0.5 mg/mL
http://www.halaven.com

Halaven® $0 Savings Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 • Phone: 1-855-EISAI-4-U (855-347-2448) Fax: 1-844-745-2350

Thank you for your interest in the HALAVEN® $0 Savings Program. Please read and complete the enrollment form in its entirety. Once eligibility has been determined you will be notified. Completion of this form and application does not guarantee enrollment.

INSTRUCTIONS: HOW TO COMPLETE THE ENROLLMENT FORM

OVERVIEW

1. Please write legibly and complete all sections to prevent delays.
2. Once completed, forward the completed form to the address or fax indicated above.
3. If the patient is eligible to participate in the HALAVEN® $0 Savings Program, a welcome letter, with information card, will be mailed to the patient and faxed to the physician.
4. If the patient is not eligible for the HALAVEN® $0 Savings Program, a denial notification will be sent to the patient and faxed to the physician.
5. Enrollment in the HALAVEN® $0 Savings Program is valid for one year from date approval. After one year, a new application must be submitted.

PATIENT INFORMATION

☐ To qualify for the program, the patient must be a US Resident.

☐ Completely fill out the entire form and answer all questions.

☐ The patient must sign and date the "PATIENT AUTHORIZATION FOR HEALTH INFORMATION USE AND DISCLOSURE" section in each place indicated. This enrollment cannot be processed without a patient's signature.

PHYSICIAN INFORMATION

☐ Physician must fill out office information completely including telephone and fax number.

☐ P.O. Box addresses will not be accepted.

☐ Physician must supply a valid DEA or NPI number.

PREFERRED SITE OF ADMINISTRATION

☐ Be sure the physician signs and dates this section, this enrollment cannot be processed without a physician's signature.

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PATIENT INFORMATION	PATIENT NAME		
DATE OF BIRTH / /	GENDER ☐ MALE ☐ FEMALE	E-MAIL	
HOME PHONE ( )	WORK PHONE ( )	If you're unavailable when we call, is it ok for us to leave a message including the prescription name, HALAVEN®? ☐ YES ☐ NO	
MAILING ADDRESS	CITY	STATE	ZIP CODE

How would you like to be notified for future communication concerning the HALAVEN® Savings Program?
☐ Mail ☐ Email

How long have you been receiving HALAVEN®?
☐ Less than 3 months ☐ 3 months or more

1. Do you currently have commercial Insurance?
☐ YES ☐ NO
If yes, what is the name of your insurance company.
_____

2. Do you certify that you are not enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare, such as Medicare Part D prescription drug benefit, Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs?
☐ YES ☐ NO

3. Do you certify that you will not seek reimbursement from any third-party payers to include a flexible spending account, a healthcare savings account or a health reimbursement account?
☐ YES ☐ NO

Fax or mail this completed enrollment form to HALAVEN®. Fax: 1-844-745-2350 Mail: HALAVEN® $0 Savings Program • 2250 Perimeter Park Drive, Suite 300 • Morrisville, NC 27560

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the back of this form and I understand that redeeming this rebate is consistent with the requirements of my health plan,

Patient Signature _____ **Date** _____ **Patient Name** _____
If the patient cannot sign, patient's personal representative must sign below. (Please print)

Guardian Name _____ **Guardian Signature** _____
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient_____

PHYSICIAN INFORMATION	☐ My office would not like to receive any fax or mail correspondence from HALAVEN® regarding patient status in the program.	☐ My office does not accept Debit Card payment	
PHYSICIAN'S NAME			
SITE NAME	OFFICE CONTACT		
ADDRESS	CITY	STATE	ZIP CODE
PHONE ( )	FAX ( )		
PHYSICIAN SPECIALTY	DEA AND STATE LICENSE #	PHYSICIAN NPI #	

PREFERRED SITE OF ADMINISTRATION (Fields below do not need to be completed if information is the same as Physician Information)	☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Other
	☐ My office would not like to receive any fax or mail correspondence from HALAVEN® regarding patient status in the program.

NAME OF PHYSICIAN OR INFUSION PROVIDER	PHYSICIAN SPECIALTY	SITE NAME
ADDRESS		
CITY	STATE	ZIP CODE
PHONE ( )		
FAX ( )		
OFFICE CONTACT		
DEA AND STATE LICENSE #	PHYSICIAN NPI #	

I certify that the information provided in this application is complete and accurate and that the product ordered hereunder is medically necessary for this patient. I understand eligibility under this Program is subject to Eisai Inc.'s approval and the patient's continuing compliance with all eligibility requirements, as set by Eisai Inc. from time to time.

Physician Signature _____ Date _____

If you have any questions about the HALAVEN® $0 Savings Program, please call 1-855-EISAI-4-U (855-347-2448).

THE EISAI ASSISTANCE PROGRAM

HALAVEN® $0 Savings Program
Enrollment Form
Please complete this form and fax to: 1-844-745-2350

Phone: 1-855-EISAI-4-U
(855-347-2448)

PATIENT AUTHORIZATION FOR HEALTH INFORMATION USE AND DISCLOSURE

I hereby authorize my health care providers and health insurer(s) to disclose to Eisai Inc., its employees, agents, and service providers involved in the HALAVEN $0 Co-Pay Program (collectively, the "Co-Pay Program") any personal health information about me that is relevant to my treatment with HALAVEN, so that I may receive assistance enrolling in the Program. I authorize the Program to use this PHI and to disclose it to my health care providers and health insurer(s) for the foregoing purpose, as well as to use and disclose my PHI to send me, my health care providers and health insurer(s) communications confirming my enrollment and/or processing the co-pay card. I also authorize the Program to use my PHI for quality assessment and improvement purposes in administering the Program. 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 HALAVEN $0 Co-Pay Program intends to use and disclose my PHI only for the purposes described herein or as required by law.

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 HALAVEN $0 Co-Pay Program either by mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, or by fax to 844-745-2350. 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	Signature	Date
Name of Legal Representative	Signature	Date

If signed by legal representative, describe the nature of his/her relationship with patient:

PATIENT ACKNOWLEDGMENT

I understand that completing this form does not ensure that I will qualify for the HALAVEN $0 Co-Pay Program. I represent that the information provided in this enrollment form is complete and accurate. I agree to notify and shall be responsible for notifying the program administrator for the HALAVEN $0 Co-Pay Program if I no longer meet the eligibility criteria for the HALAVEN $0 Co-Pay Program. 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 HALAVEN $0 Co-Pay Program, including modification of eligibility criteria and immediate termination of assistance provided by the HALAVEN $0 Co-Pay Program. I understand that I may decline to sign this form and decline being considered for the HALAVEN $0 Co-Pay Program.

Name of Patient	Signature	Date
Name of Legal Representative	Signature	Date

If signed by legal representative, describe the nature of his/her relationship with patient:

Please be sure the applicant signs and dates this section in each place indicated.
This enrollment cannot be processed without the patient's signatures.

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.