LENVIMA® (lenvatinib) capsules 10 mg and 4 mg

Eisai Patient Support Enrollment Form

Eisai Patient Support
Phone: 1-866-61-EISAI (1-866-613-4724)
Fax: 1-855-246-5192
Monday–Friday: 9AM - 6PM ET
www.eisaipatientsupport.com/lenvima

EISAI PATIENT SUPPORT OFFERS TWO OPTIONS FOR ENROLLMENT

Eisai Patient Support does not charge a fee to apply for participation in the program

Option 1: Send an ePrescription to Eisai Patient Support Pharmacy

To initiate the enrollment process into Eisai Patient Support, send an electronic prescription for LENVIMA directly to Eisai Patient Support Pharmacy.

Eisai Patient Support Pharmacy is categorized as a retail pharmacy in EMR/EHR systems and is located at: 2730 S. Edmonds Lane, #400A, Lewisville, TX 75067

The e-Prescribe ID number is 5942176.

For Both Enrollment Options:

All support offerings are available to eligible patients.

Patients may provide their signature electronically at: **www.LENVIMAConsent.com**

Option 2: Complete and Submit This Form

☑ Select all program offerings that patient should be evaluated for; complete and sign all applicable pages as directed below

Fax completed form and both sides of the patient's insurance card(s) to **1-855-246-5192**

- Note: Both physician and patient must sign this form, patient can sign electronically at www.LENVIMAConsent.com

Program Offerings

☐ **Benefits Investigation**

Helps patients understand their coverage for LENVIMA

Provider: Complete pages 1, 2, and 4

Patient: Sign top of page 4

☐ **Patient Assistance Program (PAP)**

Provides LENVIMA at no cost to eligible patients with financial need

Provider: Complete entire form

Patient: Sign top and bottom of page 4

☐ **LENVIMA Welcome Kit**

Includes key LENVIMA educational materials and helpful resources for patients receiving therapy

Provider: Complete page 1, top of page 2, and provide diagnosis/ICD-10 code. No physician signature required

Patient: Sign top of page 4

☐ **Request an ARM**

FOR OFFICE USE ONLY: Access & Reimbursement Managers (ARMs) support patients' access to prescribed Eisai products by providing relevant information and addressing provider questions regarding insurance coverage, coding, reimbursement, and patient access issues.

Patient Information

*REQUIRED FIELD

***Patient Name**		***Date of Birth**	***Gender** ☐ Male ☐ Female
***Street Address**		***City**	***State** / ***Zip**
***Patient Home Phone Number**	**Patient Cell Phone Number**	**Email**	
Preferred Language		**Preferred Contact Method** ☐ Home ☐ Cell ☐ Email	
Annual Household Income		**Number of Household Members Dependent on Income** *(Include Applicant)*	

Below, you may designate a trusted family member, friend, or caregiver as an alternate contact. By providing this information, you consent to Eisai staff sharing or discussing your private health information with this person. Eisai reserves the right to limit certain program-related communications solely to the patient and/or their alternate contact.

Alternate Contact Name	**Relationship to Patient**
Alternate Contact Primary Phone Number	**Alternate Contact Secondary Phone Number**

Patient Insurance Information

*REQUIRED FIELD

1

***Primary Insurance Type** *(If No insurance, check box and skip to next page)*

☐ No insurance ☐ Medicare ☐ Medicaid ☐ Commercial/private insurance plan ☐ VA (Veterans Affairs) ☐ Other _____

***Primary Medical Insurance Provider**	***Phone Number**	***Policy ID #**
***BIN**	***PCN**	***Group #**
***Policyholder Name**		***Policyholder Date of Birth**

2

Secondary Medical Insurance Provider	**Phone Number**	**Policy ID #**
BIN	**PCN**	**Group #**
Policyholder Name		**Policyholder Date of Birth**

If available, please provide front & back copies of the patient's insurance card when submitting this form.

LENVIMA (lenvatinib) capsules 10 mg and 4 mg

Eisai Patient Support Enrollment Form

Eisai Patient Support
Phone: 1-866-61-EISAI (1-866-613-4724)
Fax: 1-855-246-5192
Monday–Friday: 9AM - 6PM ET
www.eisaipatientsupport.com/lenvima

Physician Information

*REQUIRED FIELD

Physician Name*	**Site/Facility Name**		
Street Address*	**City***	**State***	**Zip***
Office Contact Name	**Phone Number***		
Fax Number	**Email**		
State License #*	**Tax ID #***	**NPI #***	

Prescription

Note: Medication will be shipped via specialty pharmacy to the patient's home address unless physician provides specialty pharmacy with an alternative address.

Patient Name	**Date of Birth**	**Weight**
Medication Name LENVIMA capsules	**Diagnosis/ICD Code**	

- LENVIMA is available in 4-mg and 10-mg capsules
- LENVIMA capsules are supplied in cartons containing 6 cards. Each card contains a 5-day supply of LENVIMA
- **Please check box for medication strength (required)**

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

Directions: _____

Quantity: _____ Refills: _____ Current list of allergies: _____

Current list of medications: _____

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)

Physician: Please note that you may be asked to provide a separate prescription to comply with state pharmacy law.

Pharmacy

Eisai Patient Support Pharmacy	
2730 S. Edmonds Lane, #400A, Lewisville, TX 75067	
NCPDP: 5942176 **NPI:** 1861259194	**Hours of operation: M-F** 9AM - 6PM ET

Note: Physician can send an electronic prescription for LENVIMA to Eisai Patient Support Pharmacy to initiate enrollment into Eisai Patient Support

Patient Authorization for Use and Disclosure of Health Information

By signing this Authorization, I authorize each of my physicians, pharmacists, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my personal health information, including information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Eisai Inc., its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Eisai") supporting the Eisai Patient Support Program for LENVIMA (collectively, the "Program") so that the Program may take the following steps to provide me with support offerings ("Support"):

I. Process my enrollment (or re-enrollment, as applicable) and determine my eligibility for the Program's financial assistance and copay assistance, including benefit verifications and prior authorizations support,
II. Provide me with the Program's financial assistance Support and copay assistance Support,
III. Verify, investigate, coordinate, and communicate with my Healthcare Providers and Insurers about my insurance benefits and coverage, and my medical care and prescribed medication,
IV. Facilitate dispensing of my prescription by a non-commercial pharmacy,
V. Provide me with disease management and other educational materials, information, and Support related to my treatment experience with my prescribed medication and my condition,
VI. Communicate with me about my medication and treatment, including adherence materials, reminders, health and lifestyle tips, and product and other related information,
VII. Conduct surveys, data analytics, market research, quality assurance and improvement purposes, and other internal business activities related to the Program and Eisai products and programs,
VIII. Contact me via postal mail, email, phone or text message at the number(s) I provide about the Program or any issues related to the Program.

I further authorize the use and disclosure of my Protected Health Information to my Healthcare Providers, Insurers, government agencies, other assistance programs, caregivers, or legally authorized representatives that I designate for the foregoing purposes. By designating a specific caregiver or authorized representative, I am authorizing that individual to provide information regarding my insurance plans, financial status, and other information necessary to facilitate my participation in the Program.

Continued on next page

Patient authorization for use and disclosure of health information (cont'd)

I understand that:

- Once my Protected Health Information is shared, it may no longer be protected by federal privacy laws and it could be disclosed to others. However, Eisai intends to use and share my Protected Health Information only as described in this Authorization or as otherwise permitted by law
- I may refuse to sign this Authorization, and choosing not to sign it will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program or the Support provided by the Program
- My signed Authorization will remain in effect for 5 years from the date of my signature below, or such shorter period that may be prescribed by state law
- I may revoke this Authorization at any time by mailing a request to 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, faxing a request to 1-855-246-5192, or calling 1-866-613-4724. I also understand that revoking this Authorization will make it invalid with respect to uses and disclosures of my Protected Health Information after the date my revocation letter is received, but that it will not invalidate uses and disclosures made in reliance upon the Authorization prior to that date
- I am entitled to receive a copy of this Authorization

Patient or Patient Representative Signature | Date | Name of Patient or Patient Representative

Patient Representative Relationship to Patient

Patient Assistance Program 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 Eisai Patient Support 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.

Patients with an insurance plan, employer, or any third-party entity that requires patients to apply to a manufacturer's patient assistance program instead of providing coverage, commonly known as Alternate Funding Programs (AFPs), are not eligible for Eisai's Patient Assistance Program (PAP). You agree to inform Eisai Patient Support (EPS) if you are a member of such an insurance plan or if you are applying to EPS on behalf of a patient who is a member of such an insurance plan. If at any point EPS determines that a patient is enrolled or moved into an Alternate Funding Program, participation in PAP may terminate immediately and product support will be discontinued.

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 EPS 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.

Patient or Patient Representative Signature | Date | Name of Patient or Patient Representative

Patient Representative Relationship to Patient

Note: Patients can visit www.lenvimaconsent.com to provide all digital signatures needed on this form.