

Eisai Assistance Program
Phone: 1-866-61-EISAI (1-866-613-4724) Monday through Friday, 8 am to 8 pm ET • Fax: 1-855-246-5192 • www.lenvimareimbursement.com

Through the LENVIMA Temporary Supply Program, eligible patients may receive up to 30-days' supply of LENVIMA (dispensed in up to three 10-day increments) while awaiting a coverage determination from their insurance provider. If the pharmacy to which the patient or prescriber submitted a prescription for LENVIMA does not receive a coverage determination from an insurer within five business days and the patient meets the program eligibility criteria, the patient's prescriber may complete this form and submit it to the Eisai Assistance Program to assess eligibility and dispense a temporary supply of LENVIMA to the patient at no cost.

► To receive LENVIMA through the Temporary Supply Program, please fill out the form below and fax to 1-855-246-5192.

Specialty Pharmacy	
Phone	Fax

► Patient Information

Patient Name		Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
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		

► Prescription

Eligible patients may receive up to 30-day supply of LENVIMA in three 10-day increments while their insurance coverage is being determined. This temporary supply of LENVIMA will be shipped to the patient's home address.

Medication Name: LENVIMA capsules **Medication Dose*†:** _____

Dose	Daily Capsules in Blister Card	Quantity for 10 Days Supply
24 mg	10 mg, 10 mg, 4 mg	#20 caps of 10 mg; #10 caps of 4 mg
20 mg	10 mg, 10 mg	#20 caps of 10 mg
18 mg	10 mg, 4 mg, 4 mg	#10 caps of 10 mg; #20 caps of 4 mg
14 mg	10 mg, 4 mg	#10 caps of 10 mg; #10 caps of 4 mg
12 mg	4 mg, 4 mg, 4 mg	#30 caps of 4 mg
10 mg	10 mg	#10 caps of 10 mg
8 mg	4 mg, 4 mg	#20 caps of 4 mg
4 mg	4 mg	#10 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: 10 day supply **Refills:** 2

Physician Signature: _____ **Date:** _____

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

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► Patient Information

Patient Name	Date of Birth
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► Physician Information

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

Terms and Conditions:

- To be eligible for the LENVIMA Temporary Supply Program, a patient must: (1) have been prescribed LENVIMA by a licensed healthcare provider for an FDA-approved indication; (2) have insurance; and (3) have experienced a delay in a coverage determination of at least five business days.
- No patient, pharmacy, or payor should be billed for the temporary supply of LENVIMA. Patient must not submit any claim for reimbursement for product dispensed pursuant to this program to any third party payor, including Medicare, Medicaid, or any other federal or state health care program. Patient cannot apply the value of the free product received through this program toward any government insurance benefit out-of-pocket spending calculations such as Medicare Part D True Out-Of-Pocket Costs (TrOOP).
- The temporary supply of LENVIMA is not contingent on any past or future purchases of LENVIMA or other products manufactured or marketed by Eisai, Inc.
- Limit of one enrollment (up to 30-day supply) per patient.
- Eisai reserves the right to rescind, revoke or amend the LENVIMA Temporary Supply Program at any time without notice.
- Additional terms and conditions and eligibility criteria apply. Contact the Eisai Assistance Program for additional information.

► 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.

In addition, I have confirmed that this patient is experiencing a delay in a coverage determination for LENVIMA of at least five business days and meets program eligibility criteria. I understand that the Eisai Assistance Program will reach out to the pharmacy listed above to confirm.

Physician Signature (no stamps)

Date

