LEQEMBI Companion™ program Enrollment Form

LEQEMBI (lecanemab-irmb) | LEQEMBI companion™

Phone: 1-833-453-7362 | Fax: 1-833-770-7017 | M-F: 8 AM-8 PM ET

Patient's name _____ DOB (MM/DD/YYYY) _____

Prescribers to complete pages 1–5, patient to complete pages 6–11, or enroll digitally at LEQEMBIEnrollment.com.

Program Offerings

Physician to select from the following program offerings to enroll

Eisai Patient Support (EPS) offerings

EPS offers information and resources to help you access LEQEMBI®.

Provider: Complete all sections. Sign pages 3 and 5.

Patient: Complete and sign pages 6–11.

☐ **Benefits investigation**

Helps patients understand their coverage for LEQEMBI.

☐ **Copay Assistance Program**

Helps eligible commercially insured patients with their LEQEMBI cost.

☐ **Patient Assistance Program (PAP)**

Provides LEQEMBI at no cost to eligible patients with financial need. Valid prescription required; see pharmacy information on page 3.

LEQEMBI IQLIK™ Injection Support Offerings

Reminder: LEQEMBI IQLIK injection support offerings are ONLY available to patients on IQLIK Subcutaneous (SubQ) Maintenance treatment.

☐ **LEQEMBI IQLIK Welcome Kit**

- Demo Autoinjector Kit
- Folder with educational resources

Patient: Complete and sign pages 6-11.

☐ **Nurse Educator***

One-on-one injection support

Patients prescribed LEQEMBI IQLIK may access one-on-one injection support either in-person or virtually.

*Nurse Educators are provided by Eisai and Biogen (manufacturers of LEQEMBI) and do not work under the direction of your healthcare provider.

Patient: Complete and sign pages 6-11.

Prescriber Information

Completion required regardless of program offering selection

Prescriber's first name† _____ Prescriber's last name† _____

Prescriber's title _____ If NP or PA, under direction of doctor _____

Prescriber's NPI† _____ Medicare PTAN† _____ Tax ID† _____

Office address† _____ City† _____ State† _____ ZIP† _____

Office phone† _____ Office fax _____

Office contact and title _____ Office contact phone _____

Office contact email _____

Healthcare organization name _____

†Required field.

Patient's name _____ DOB (MM/DD/YYYY) _____

Treatment Information

Completion required for all program offerings except the LEQEMBI Companion Welcome Kit

☐ **LEQEMBI Infusion Initiation*†** ☐ **LEQEMBI Infusion Maintenance*†** ☐ **LEQEMBI IQLIK SubQ Maintenance*†**

Primary ICD-10 code* _____ Secondary ICD-10 code _____

Select procurement method below. If selecting ''Specialty pharmacy,'' please also provide preferred pharmacy.

☐ **Site purchase** ☐ **Specialty pharmacy** ☐ **Undetermined**

Preferred pharmacy _____ Phone* _____ Fax _____

Infusion Site Information

Completion only required for LEQEMBI Infusion patients

Do you require assistance in locating an infusion site for your patient?* ☐ **Yes** ☐ **No**

If you have selected No above and you are referring the patient to a known treatment site, please fill out the information below:

Name of infusion site or healthcare provider* _____

Street address* _____

City* _____ State* _____ ZIP* _____

Office contact and title* _____

Phone* _____ Fax _____

Treatment site NPI* _____ Treatment site tax ID* _____

Insurance Information

Is the patient insured? ☐ **Yes** ☐ **No**

If insured, please fill out the information below or attach a copy of the front and back of the patient's insurance card(s).

Is prior authorization in place with infusion provider? ☐ **Yes** Auth # _____ ☐ **No**

	Primary Insurance	**Secondary Insurance**	**Pharmacy Benefit**
Insurance name			
Subscriber name (if not patient)			
Subscriber DOB (MM/DD/YYYY)			
Subscriber/Policy ID #			
Group #			
Insurance phone			

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

Patient's name _____ DOB (MM/DD/YYYY) _____

Prescription Information for LEQEMBI*

Patient's first name† _____ Patient's last name† _____

DOB (MM/DD/YYYY)† _____ Known drug allergies _____ ☐ NKDA

Patient's weight (lbs)†‡ _____ Concurrent medications _____

Prescriber name (First, Last) _____ Prescriber phone _____

Prescriber address _____ Prescriber's NPI† _____

LEQEMBI Infusion Therapy (lecanemab-irmb 100 mg/mL)

Infuse 10 mg/kg intravenously over 60 minutes every _____ weeks. 28-day supply

Refills _____

LEQEMBI IQLIK Subcutaneous Injection (360 mg/1.8 mL single dose)

Inject 360 mg subcutaneously once a week. (4 pens) 28-day supply

Refills _____

Communication Preferences

Primary case contact? ☐ **Prescriber** ☐ **Infusion site**

Preferred communication method? ☐ **Fax only** ☐ **Fax and phone updates**

Fax communications to be sent to: ☐ **Infusion site only** ☐ **Prescriber only** ☐ **Both**

Healthcare Provider Attestation and Consent

I represent and warrant that I am authorized pursuant to the laws of my state of licensure to prescribe LEQEMBI. I certify that the information provided in this application is complete and accurate and that I have prescribed LEQEMBI based on my independent professional judgment of medical necessity and have taken into account relevant patient safety considerations and the full prescribing information. By enrolling my patient in this Program, I agree that I may be contacted by Eisai's Medical team to receive educational information regarding LEQEMBI.

_____ _____

Prescriber certification†
(ORIGINAL SIGNATURE REQUIRED)

Date†

Pharmacy Information

HCPs can send prescriptions to the following pharmacy electronically or via fax. Required for PAP and LEQEMBI Infusion TSP evaluation only.

Eisai Patient Support Pharmacy

2730 S. Edmonds Lane, Suite 400A, Lewisville, TX 75067
NCPDP: 5942176 **NPI:** 1861259194 **Fax:** 1-833-770-7017

Hours of operation:
M-F 9 AM-6 PM ET

Eisai Patient Support Pharmacy is operated by Sonexus™ Health Pharmacy Services, LLC.

*Prescriber: Please attach a separate prescription if this section does not comply with your state's prescription law.
†Required field.
‡LEQEMBI is dosed based on patient's actual weight.

Patient's name _____ DOB (MM/DD/YYYY) _____

LEQEMBI Infusion Temporary Supply Program terms and conditions

The Temporary Supply Program provides a temporary free supply of up to 75 days of LEQEMBI infusions for eligible, commercially insured patients new to LEQEMBI therapy awaiting a final coverage determination from their insurance provider for 5 or more business days and the patient's provider has submitted a first-level appeal of the prior authorization denial. Patient must have a valid prescription for LEQEMBI infusion for an FDA-approved indication and meet certain financial need criteria. Not available for uninsured patients or patients enrolled in state and federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE. Eisai reserves the right to rescind, revoke, or amend this Program at any time without notice. Please see complete terms and conditions, and full Prescribing Information at EisaiPatientSupport.com/LEQEMBI.

LEQEMBI Patient Assistance Program terms and conditions

The Patient Assistance Program for LEQEMBI provides free drug for eligible patients who meet financial need and insurance coverage criteria. Patient must have a valid prescription for LEQEMBI for an FDA-approved indication. Eisai reserves the right to rescind, revoke, or amend this Program at any time without notice. Please see complete terms and conditions, and full Prescribing Information at EisaiPatientSupport.com/LEQEMBI.

LEQEMBI Copay Assistance Program terms and conditions

Patient must be prescribed LEQEMBI for an FDA-approved indication and have private, commercial health insurance that provides coverage for LEQEMBI. The offer is not valid for patients enrolled in state and federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE, that cover outpatient care, including for physician-administered or prescription drugs, or otherwise cover LEQEMBI. The offer is not valid for uninsured or self-paying patients, or for LEQEMBI treatments reimbursed in full by any third-party payer. Eligible patients who participate in the Program may pay as little as $0 out-of-pocket per date of treatment. Eisai Inc. will pay up to $10,000 per calendar year toward an eligible patient's out-of-pocket costs for LEQEMBI, including deductibles, copays, and coinsurances. Depending on the patient's insurance plan, the patient could have additional financial liability for any amount over Eisai's maximum benefit.

Additional Copay Assistance Program terms and conditions for LEQEMBI Infusion: Supporting documentation, including a CMS-1500 or UB-04 form and an insurance explanation of benefits (EOB) with itemized charges that include the billing code for LEQEMBI, must be submitted to the LEQEMBI Copay Assistance Program within 365 days of the date of treatment or the request will be rejected.

Please see complete terms and conditions on pages 10-11 of this form, and full Prescribing Information at EisaiPatientSupport.com/LEQEMBI.

Patient's name _____ DOB (MM/DD/YYYY) _____

LEQEMBI Patient Assistance, Temporary Supply, and Copay Assistance Programs: Healthcare provider attestation

I have read and agree to comply with the LEQEMBI Infusion Temporary Supply Program and LEQEMBI Patient Assistance Program terms and conditions set forth in this enrollment form and also available at EisaiPatientSupport.com/LEQEMBI. I certify that any medications supplied by Eisai under the Patient Assistance Program and the Temporary Supply Program (together, the "Programs"), as applicable, will be provided at no cost to the eligible, enrolled patient named on this form for an FDA-approved indication only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (including federal healthcare programs such as Medicare and Medicaid) for reimbursement. I certify that I will maintain free LEQEMBI received from the Programs separately from commercial inventory, administer the LEQEMBI only to the enrolled patient named on this form, and discard unused amounts in open vials (as applicable). I understand that for LEQEMBI Subcutaneous, the Programs will ship LEQEMBI directly to the patient's home address entered on the enrollment form unless otherwise indicated by the prescriber.

I understand that during the Program enrollment period, patients must receive all LEQEMBI doses through the Program only. If the enrolled patient is no longer on therapy or otherwise cannot use the LEQEMBI provided through the Programs, I agree to promptly contact the LEQEMBI Companion program to arrange for product return or disposal. I understand eligibility under these Programs is subject to the approval of Eisai Inc. and the patient's and provider's continuing compliance with all eligibility and Program requirements, as set by Eisai Inc. from time to time. I agree to provide Eisai, or its authorized agent(s), access to the medical, financial and insurance records that this patient has authorized (in a signed, written authorization) me to disclose to Eisai and its authorized representatives for the purposes of verifying the patient's eligibility status for the Programs and the patient's receipt of any product(s) provided to him or her through the Programs.

I have read and agree to comply with the LEQEMBI Copay Assistance Program terms and conditions set forth on this enrollment form and also available at EisaiPatientSupport.com/LEQEMBI. I certify that, to the best of my knowledge, the patient meets the eligibility criteria set forth in the LEQEMBI Copay Assistance Program terms and conditions. I understand patient participation in the LEQEMBI Copay Assistance Program is subject to Eisai Inc.'s confirmation of patient eligibility and the patient's and my continuing compliance with all LEQEMBI Copay Assistance Program terms and conditions. I agree that I will not charge the patient for the copay or coinsurance prior to treatment with LEQEMBI. I certify that my office will apply all amounts received from the LEQEMBI Copay Assistance Program to the enrolled patient's out-of-pocket cost for LEQEMBI.

Prescriber signature* _____ Date* _____

Patient must fill out pages 6-11 to complete the form

*Required field.

LEQEMBI Companion™ program Enrollment Form

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Patient's name _____ DOB (MM/DD/YYYY) _____

Patient to complete pages 6-11. The patient will only be evaluated for the program offerings their provider selects on this form, with the exception of the LEQEMBI IQLIK Welcome Kit and Nurse Educator offering. While your signature is only required for the selected programs, you may sign the additional attestations to be considered for programs in the future. Your prescriber has shared your insurance details with the LEQEMBI Companion program to help you get started. If you'd like to provide additional insurance information or confirm accuracy, please contact at 1-833-453-7362.

LEQEMBI IQLIK Injection Support Offerings

Reminder: LEQEMBI IQLIK injection support offerings are ONLY available to patients on IQLIK Subcutaneous (SubQ) Maintenance treatment.

☐ **LEQEMBI IQLIK Welcome Kit**

This kit includes:

* Demo Autoinjector Kit
* Folder with educational resources

Nurse Educator*

I would like to enroll in the LEQEMBI COMPANION Nurse Educator Program. I understand that if I elect to receive the injection training, I agree to have a Nurse Educator come to my home for the training, or to receive the training on a video call, on a secure platform by LEQEMBI COMPANION.

*Nurse Educators are provided by Eisai and Biogen (manufacturers of LEQEMBI) and do not work under the direction of your healthcare provider.

☐ Yes, opt-in

☐ I confirm I have been prescribed LEQEMBI IQLIK.
Reminder: You must be prescribed LEQEMBI IQLIK to opt in to Nurse Educator support.
If opting in, fill out the Patient Information section and HIPAA consent on pages 7 and 8.

Patient Information

ALL FIELDS REQUIRED

Patient's name (First, Middle, Last) _____ DOB (MM/DD/YYYY) _____ Sex ☐ **Male** ☐ **Female**

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Alternate contact _____ Relationship _____ Phone number _____

Prescriber name (First, Last) _____ Prescriber phone _____

Communication Preferences

Regardless of your selection below, LEQEMBI Companion may need to reach you via phone to confirm eligibility for certain program offerings

Preferred contact method: ☐ **Home phone** ☐ **Cell phone** ☐ **Email** | OK to leave a message? ☐ **Yes** ☐ **No**

Best time to call: ☐ **Morning** ☐ **Noon** ☐ **Evening**

Preferred language: ☐ **English** ☐ **Spanish** ☐ **Other** _____

Patient's name _____ DOB (MM/DD/YYYY) _____

Collection, use, and disclosure of health information

As part of the LEQEMBI Companion program for LEQEMBI (the "Program"), Eisai, its affiliates, vendors, agents, collaboration partners, and representatives supporting the Program (collectively, "Eisai") collect certain personal information about you, including but not limited to information about your health condition, diagnoses, treatment, insurance coverage, contact information and address, Social Security number, payment, name and other identifiers, etc. (collectively, "Health Information"). Please review the below disclosures of how that information will be processed under certain circumstances and the related authorizations or consents for those situations.

Consent for Eisai to process your health information

Eisai collects, uses, and discloses (collectively, "Process") your Health Information as necessary to provide you the support offerings in our Program. If you choose not to provide this information, we cannot provide our support offerings. For more information on our data processing practices and rights you may have, please see our Privacy Policy at https://us.eisai.com/privacy-policy. If you or your healthcare provider provide Health Information and later change your mind, you may withdraw your consent for future processing or request deletion of your information (subject to applicable law) at any time by contacting the Program at 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, faxing a request to 1-833-770-7017, or calling 1-833-453-7362. By signing below, I consent to Eisai Processing my Health Information.

Name of patient _____ Patient signature _____ Date _____

Name of authorized representative _____ Authorized representative signature _____ Date _____

Relation to patient _____

Authorization for Use and Disclosure of Health Information

Each of your physicians, infusion sites, pharmacists, and other healthcare providers (together, "Healthcare Providers"), as well as each of your health insurers ("Insurers"), may need to use or disclose your Health Information to Eisai (as defined above) so that the LEQEMBI Companion program for LEQEMBI (the "Program") may use the information to provide you with the support offerings ("offerings") below:

I. Process your enrollment (or re-enrollment, as applicable) and determine eligibility for the Program's financial assistance, copay assistance, and temporary supply support offerings, including benefit verifications and prior authorizations support;
II. Provide you with the Program's online support, financial assistance offerings, and copay assistance support offerings;
III. Verify, investigate, coordinate, and communicate with your Healthcare Providers and Insurers about your insurance benefits and coverage, and your medical care and prescribed medication;
IV. Facilitate dispensing of your prescription by a non-commercial Pharmacy;
V. Provide you with disease management and other educational materials, information, and support offerings related to your treatment experience with your prescribed medication and condition;

Patient's name _____ DOB (MM/DD/YYYY) _____

Authorization for Use and Disclosure of Health Information (cont'd)

VI. Communicate with you about your medication and treatment, including adherence materials, reminders, health and lifestyle tips, and product and other related information;
VII. Provide you with the disease and medication education, and injection training by a LEQEMBI Companion Nurse Educator;
VIII. 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; and
IX. Contact you via postal mail, email, phone, or text message at the number(s) you provide about the Program or any issues related to the Program.

By signing the authorization below, I authorize the uses and disclosures of my Health Information described above in Sections I-IX. I further authorize the use and disclosure of my 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.

I understand that:

- Once my 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 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 its support offerings.
- My signed Authorization will remain in effect for 5 years or such shorter period required 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 1-833-770-7017, or calling 1-833-453-7362. I also understand that revoking this Authorization will make it invalid with respect to uses and disclosures of my 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's name _____ DOB (MM/DD/YYYY) _____

Authorization for Use and Disclosure of Health Information (cont'd)

Signature required for LEQEMBI Companion enrollment

Name of patient	Patient signature	Date
Name of authorized representative	Authorized representative signature	Date
	Relation to patient	

Consent to receive LEQEMBI marketing communications (OPTIONAL)

☐ **Yes.** By checking this box, I consent to Eisai, its affiliates and service providers contacting me through emails and online platforms with reminders, education, lifestyle tips, and other resources relating to LEQEMBI and Alzheimer's disease generally. In doing so, I understand that Eisai may collect and use the information about me, some of which may be considered "sensitive" or "health data" and further share it with its service providers for Eisai marketing (e.g., product news and resources including LEQEMBI). I understand that I may withdraw my consent at any time by clicking the "unsubscribe" link at the bottom of Eisai emails or following the instructions on our "Your Choices and Rights" page (available here: https://us.eisai.com/privacy-policy/your-choices-and-rights). **Email address is required.**

LEQEMBI Infusion Temporary Supply Program terms and conditions

The Temporary Supply Program provides a temporary free supply of up to 75 days of LEQEMBI infusions for eligible, commercially insured patients new to LEQEMBI infusion therapy awaiting a final coverage determination from their insurance provider for 5 or more business days and the patient's provider has submitted a first-level appeal of the prior authorization denial. Patient must have a valid prescription for LEQEMBI infusion for an FDA-approved indication and meet certain financial need criteria. Not available for uninsured patients or patients enrolled in state and federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE. Eisai reserves the right to rescind, revoke, or amend this Program at any time without notice. To review complete terms and conditions, visit EisaiPatientSupport.com/LEQEMBI.

LEQEMBI Patient Assistance Program terms and conditions

The Patient Assistance Program for LEQEMBI provides free drug for eligible patients who meet financial need and insurance coverage criteria. Patient must have a valid prescription for LEQEMBI for an FDA-approved indication. Eisai reserves the right to rescind, revoke, or amend this Program at any time without notice. To review complete terms and conditions, visit EisaiPatientSupport.com/LEQEMBI.

LEQEMBI Patient Assistance and Temporary Supply Programs attestation

Signature required for LEQEMBI Infusion Temporary Supply Program and LEQEMBI Patient Assistance Program enrollment

I certify that all of the information provided in this application is complete and accurate. I understand that completing this form does not ensure that I will qualify for the LEQEMBI Patient Assistance Program ("PAP") or the Temporary Supply Program ("TSP") (together, the "Programs"). I understand that Program enrollment will terminate if LEQEMBI is no longer prescribed to me. I understand that during the Program enrollment period, I must receive all LEQEMBI doses through the Program only. I agree to notify and shall be responsible for notifying the LEQEMBI Companion program for LEQEMBI at 1-833-453-7362 immediately if anything changes with my LEQEMBI prescription, income, or my insurance coverage. I understand and agree that I will not seek reimbursement or credit from, or submit a claim for LEQEMBI provided through the Programs to any insurer, health plan, or government program (such as Medicare or Medicaid). I also understand and agree that I may not seek to have any part of the value of the LEQEMBI provided to me free of charge from the Programs count towards any applicable out-of-pocket spending calculations for drugs (eg, deductible, out-of-pocket cap, or True Out of Pocket ["TrOOP"] associated with my insurance). I understand that the provision of LEQEMBI as part of the Programs is not contingent on any future purchase of LEQEMBI.

Patient's name _____ DOB (MM/DD/YYYY) _____

I understand that Eisai Inc. reserves the right at any time and without notice to me to modify and/or discontinue the PAP and/or TSP (in whole or in part), including modification of eligibility criteria and immediate termination of assistance provided by the PAP and TSP. I understand that I may decline to sign this form and decline to be evaluated for the PAP and TSP.

I understand that verification of my income may be required in order for LEQEMBI Companion to assess my Program eligibility. By signing below, I authorize Eisai Inc. and its service providers administering the PAP and TSP to obtain from Experian Health the financial information from my credit profile or other financial information that Eisai needs to determine my financial eligibility in Eisai's PAP. I also agree to provide Eisai with additional financial documentation in a timely manner, if so requested.

Name of patient

Patient signature

Date

Name of authorized representative

Authorized representative signature

Date

Relation to patient

LEQEMBI Copay Assistance Program terms and conditions

Patient must be prescribed LEQEMBI for an FDA-approved indication. Patient must have private, commercial health insurance that provides coverage for LEQEMBI. The offer is not valid for patients enrolled in state and federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE, that cover outpatient care, including for physician-administered or prescription drugs, or otherwise cover LEQEMBI. The offer is not valid for uninsured or self-paying patients, or for LEQEMBI treatments reimbursed in full by any third-party payer. Patient must be 18 years or older. Patient must be a resident of, and product must be administered in, the United States or Puerto Rico.

Eisai Inc. will pay up to $10,000 per calendar year toward an eligible patient's out-of-pocket costs for LEQEMBI, including deductibles, copays, and coinsurances. Eligible patients who participate in the Program may pay as little as $0 out-of-pocket per date of treatment. Depending on the patient's insurance plan, patient could have additional financial liability for any amount over Eisai's maximum benefit. The offer is not valid for any other out-of-pocket costs, including medical administration charges. The LEQEMBI Copay Assistance Program will process eligible claims for patient out-of-pocket costs for LEQEMBI incurred for product administered up to 180 days prior to the date the patient is enrolled in the program. For patients prescribed LEQEMBI infusions, by enrolling in the program and accepting payment, provider agrees to put the value of the patient LEQEMBI Copay Assistance Program directly toward the patient's out-of-pocket costs for LEQEMBI Infusions only. Patient and provider/pharmacy agree not to seek reimbursement for any or all of the benefit received by the patient through the LEQEMBI Copay Assistance Program and are responsible for complying with all requirements to disclose to insurance carriers and third-party payers the benefit received from the LEQEMBI Copay Assistance Program. The offer may not be combined with any other discount, coupon, free trial, or offer. Federal law prohibits the selling, purchasing, trading, or counterfeiting of this offer. Void outside the USA and where prohibited by law. Eisai Inc. reserves the right to rescind, revoke, or amend this offer at any time without notice. The value of this offer is not contingent on any prior or future purchases. This offer is solely intended to provide savings on the purchase of LEQEMBI. This offer may not be accepted by all providers, pharmacies or alternate sites of care. The LEQEMBI Copay Assistance Program is not an insurance program. There will be no membership fees.

Additional Copay Assistance Program terms and conditions that apply to the LEQEMBI Infusion Copay Assistance Program ONLY: In order to be eligible for reimbursement under the LEQEMBI Copay Assistance Program, claims for LEQEMBI infusions must be submitted by provider to patient's private health insurance separately from other services and products. Additional instructions regarding required documentation in support of each claim will be provided by the program following confirmation of eligibility and enrollment. Upon enrollment in the program, each patient will be issued a 16-digit virtual debit card. By enrolling in this program, the patient is providing consent for the LEQEMBI Copay Assistance Program to provide payment information for any approved claims, in the form of the 16-digit virtual debit card number, directly to the provider or alternate site of care identified on this enrollment form to be applied directly to the patient's out-of-pocket costs for LEQEMBI infusions. If provider has already received payment from the patient for the patient's out-of-pocket cost for LEQEMBI infusions covered by the program, provider agrees to refund the amounts received back to the patient.

Patient's name _____ DOB (MM/DD/YYYY) _____

LEQEMBI Copay Assistance Program patient attestation

Signature required for Copay Assistance Program enrollment

I understand that completing this form does not ensure that I will qualify for the LEQEMBI Copay Assistance Program. I have read and agree to comply with the terms and conditions for the LEQEMBI Copay Assistance Program, set forth on this enrollment form and also available at EisaiPatientSupport.com/LEQEMBI.

My signature below certifies that I have completed all of the sections of the form completely, accurately, and to the best of my knowledge. I further certify (1) that I am not enrolled in any federal or state subsidized healthcare program, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE, that cover outpatient care, including for physician-administered or prescription drugs, or otherwise cover LEQEMBI; (2) that I have disclosed all of my current insurance coverage; and (3) that I will not seek reimbursement for my out-of-pocket expenses from any third party payers including from a flexible spending account, a healthcare savings account, or a health reimbursement account.

I agree to notify and shall be responsible for notifying the program administrator for the LEQEMBI Copay Assistance Program if I no longer meet the eligibility criteria for the LEQEMBI Copay Assistance Program.

If I am enrolled in the LEQEMBI Infusion Copay Assistance Program, I also provide consent for the LEQEMBI Copay Assistance Program to provide payment information for approved claims, in the form of a 16-digit virtual debit card number, directly to the provider, pharmacies, or alternate site of care identified on this enrollment form to be applied directly to my out-of-pocket costs for LEQEMBI.

I understand that the benefit available under the LEQEMBI Copay Assistance Program is limited to my out-of-pocket cost for LEQEMBI only. The program does not cover any other out-of-pocket costs, including medical administration charges.

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 LEQEMBI Copay Assistance Program, including modification of eligibility criteria and immediate termination of assistance.
I understand that I may decline to sign this form and decline to be considered for the LEQEMBI Copay Assistance Program.

Name of patient _____ Patient signature _____ Date _____

Name of authorized representative _____ Authorized representative signature _____ Date _____

Relation to patient _____