

# Eisai Patient Support Enrollment Form

Phone: 1-833-453-7362  
Fax: 1-833-770-7017  
Monday–Friday: 8 AM–8 PM ET

## HCP use

This enrollment form is for Eisai Patient Support (EPS). Upon enrollment, EPS will conduct a benefits investigation to understand patient coverage, and will assess patient eligibility for the Copay Assistance Program and the Patient Assistance Program. **Required fields are marked with an asterisk.** Please note that a completed patient enrollment form and your patient's signature are required to complete enrollment. Patients can sign the form electronically by visiting [LEQEMBIConsent.com](http://LEQEMBIConsent.com).

Fax the completed form and a copy of both sides of patient's insurance cards to 1-833-770-7017. To speak to a representative about the programs available through EPS, please call 1-833-453-7362, Monday through Friday, 8 AM to 8 PM Eastern Time.

## Patient and medical insurance information

## ALL FIELDS REQUIRED

Patient's name (First, Middle, Last)	DOB (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address	City	State	Zip
Home phone	Cell phone	<input type="checkbox"/> OK to leave a message	
Email address	Preferred language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		
Preferred contact <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Email	Best time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		
Caregiver's name	Relationship	Phone number	

## Primary insurance information

<input type="checkbox"/> No insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial/private insurance plan <input type="checkbox"/> Other	
Primary insurance company	Phone number
Policy/Member ID	Group/Account number
Policy holder name (If the patient is not the employee/policy holder)	DOB (MM/DD/YYYY if the patient is not the employee/policy holder)

## Secondary insurance information (Please complete if applicable)

<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial/Private insurance plan <input type="checkbox"/> Other	
Secondary insurance company	Phone number
Policy/Member ID	Group/Account number
Policy holder name (If the patient is not the employee/policy holder)*	DOB (MM/DD/YYYY if the patient is not the employee/policy holder)

\*If patient has additional health insurance coverage beyond the fields provided, please provide front and back copies of the patient's additional insurance cards with the submission of this form.

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## Patient diagnosis information

Primary ICD-10 code*	Secondary ICD-10 code
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## Prescriber information

Prescriber's first name*	Prescriber's last name*		
Prescriber's title	If NP or PA, under direction of Dr		
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	

\*Required field.

## 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 for this patient, based on my independent professional judgment of medical necessity and have taken into account relevant patient safety considerations and the full Prescribing Information. I understand that I must submit a LEQEMBI prescription to the pharmacy listed below. 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*

### Sonexus™ Health Pharmacy Services (SHPS)

2730 S. Edmonds Ln, Suite 400, Lewisville, TX 75067  
NCPDP: 5910206 NPI: 1447680210 Fax: 1-833-770-7017

**Hours of operation:**  
M-F 8 AM-5 PM CT

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## Treatment site information

Select only one of the two options below, and fill out the appropriate information for that option.

Prescriber will administer LEQEMBI

**How does your site intend to procure therapy** (check only one)\*

- Site purchase  
 Specialty pharmacy  
 Undetermined

**OR**

Prescriber will refer LEQEMBI treatment to another site

**How does your site intend to refer** (check only one)\*

- I require assistance in locating an infusion site  
 I am referring the patient to the following infusion site or healthcare provider

For this selection, do **NOT** fill out the information below.

For this selection, fill out the information below.

Name of infusion site or healthcare provider*		Is infusion site primary case contact?*	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Street address*		Send program communications to (check only one)*	
		<input type="checkbox"/> Infusion site only <input type="checkbox"/> Prescriber only <input type="checkbox"/> Both	
City*	State*	Zip*	
Office contact and title*			
Phone*		Fax	
Treatment site NPI*		Treatment site tax ID*	

\*Required field.

## LEQEMBI Temporary Supply Program terms and conditions

The Temporary Supply Program provides a temporary free supply of up to 75 days of LEQEMBI for eligible, commercially insured patients awaiting a coverage determination from their insurance provider for 5 or more business days. Patient must have a valid prescription for LEQEMBI 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](http://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](http://EisaiPatientSupport.com/LEQEMBI).

## 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. 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.

The benefit available under the LEQEMBI Copay Assistance Program is limited to patient's out of pocket cost for LEQEMBI, as indicated in documentation provided by the patient's health insurance provider, 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. 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, 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. Supporting documentation must be submitted to the LEQEMBI Copay Assistance Program within 365 days of the date of treatment or the request will be rejected. In order to be eligible for reimbursement under the LEQEMBI Copay Assistance Program, claims for LEQEMBI

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## LEQEMBI Copay Assistance Program terms and conditions (cont'd)

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. 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.

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. 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 only. If provider has already received payment from the patient for the patient's out-of-pocket cost for LEQEMBI covered by the program, provider agrees to refund the amounts received back to the patient.

Patient and provider agree not to seek reimbursement for any or all of the benefit received by the patient through the LEQEMBI Copay Assistance Program. Patients and providers 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 or alternate sites of care. The LEQEMBI Copay Assistance Program is not an insurance program. There will be no membership fees. This offer will expire December 31, 2023.

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

I have read and agree to comply with the LEQEMBI Temporary Supply and Patient Assistance Program terms and conditions set forth in this enrollment form and also available at [EisaiPatientSupport.com/LEQEMBI](https://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 Program separately from commercial inventory, administer the LEQEMBI only to the enrolled patient named on this form, and discard unused amounts in open vials. 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 Eisai Patient Support 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 Program and the patient's receipt of any product(s) provided to him or her through the Program.

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](https://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\*

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## Patient use

This enrollment form is for Eisai Patient Support (EPS). EPS provides information and resources to help patients get access to LEQEMBI, including benefits verification, prior authorization and appeal information, and financial assistance information. To speak to a representative about enrollment and the programs available through EPS, please call 1-833-453-7362, Monday through Friday, 8 AM to 8 PM Eastern Time.

Patients may fill out this form and either fax it to 1-833-770-7017 or bring it in to their healthcare provider's office, or their healthcare provider may assist patients in office to complete the form. **All signatures are required.** To expedite enrollment, patients can provide electronic signatures by going to [LEQEMBIConsent.com](http://LEQEMBIConsent.com).

## Patient and medical insurance information

## ALL FIELDS REQUIRED

Patient's name (First, Middle, Last)	DOB (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address	City	State	Zip
Home phone	Cell phone	<input type="checkbox"/> OK to leave a message	
Email address	Preferred language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		
Preferred contact <input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Email	Best time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		
Caregiver's name	Relationship	Phone number	
Physician name (First, Last)	Physician phone		

## Primary insurance information (Please complete if applicable)

No insurance  Medicare  Medicaid  Commercial/private insurance plan  Other

Primary insurance company	Phone number
Policy/Member ID	Group/Account number
Policy holder name (If the patient is not the employee/policy holder)	DOB (MM/DD/YYYY if the patient is not the employee/policy holder)

## Secondary insurance information (Please complete if applicable)

Medicare  Medicaid  Commercial/Private insurance plan  Other

Secondary insurance company	Phone number
Policy/Member ID	Group/Account number
Policy holder name (If the patient is not the employee/policy holder)*	DOB (MM/DD/YYYY if the patient is not the employee/policy holder)

\*If patient has additional health insurance coverage beyond the fields provided, please provide front and back copies of the patient's additional insurance cards with the submission of this form.

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### Patient use (cont'd)

#### Patient authorization for use and disclosure of health information

By signing this Authorization, I authorize each of my physicians, infusion sites, 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 LEQEMBI (collectively, the “Program”) so that the Program may take the following steps to provide me with support services (the “Services”):

- I. Process my enrollment (or re-enrollment, as applicable) and determine my eligibility for the Program’s financial assistance, copay assistance, and temporary supply Services, including benefit verifications and prior authorizations support,
- II. Provide me with the Program’s online support, financial assistance Services, and copay assistance Services,
- 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 Services 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,

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### Patient use (cont'd)

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.

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 Services 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 1-833-770-7017, 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 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

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## Patient use (cont'd)

### Patient authorization for use and disclosure of health information

*Signature required for Eisai Patient Support enrollment*

_____	_____	_____
Name of patient	Patient signature	Date
_____	_____	_____
Name of legal representative	Legal representative signature	Date
	_____	
	Relation to patient	

### LEQEMBI Temporary Supply Program terms and conditions

The Temporary Supply Program provides a temporary free supply of up to 75 days of LEQEMBI for eligible, commercially insured patients awaiting a coverage determination from their insurance provider for 5 or more business days. Patient must have a valid prescription for LEQEMBI 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](http://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](http://EisaiPatientSupport.com/Leqembi).

### LEQEMBI Patient Assistance and Temporary Supply Programs attestation

*Signature required for Temporary Supply Program and 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 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 agree to notify and shall be responsible for notifying the Eisai Patient Support Program (“EPS”) 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.



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## Patient use (cont'd)

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 EPS 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 legal representative

\_\_\_\_\_  
Legal 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. 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.

The benefit available under the LEQEMBI Copay Assistance Program is limited to patient's out of pocket cost for LEQEMBI, as indicated in documentation provided by the patient's health insurance provider, 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. 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, 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. Supporting documentation must be submitted to the LEQEMBI Copay Assistance Program within 365 days of the date of treatment or the request will be rejected. In order to be eligible for reimbursement under the LEQEMBI Copay Assistance Program, claims for LEQEMBI 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. 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.

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. 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 only. If provider has already received payment from the patient for the patient's out-of-pocket cost for LEQEMBI covered by the program, provider agrees to refund the amounts received back to the patient.

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## Patient use (cont'd)

Patient and provider agree not to seek reimbursement for any or all of the benefit received by the patient through the LEQEMBI Copay Assistance Program. Patients and providers 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 or alternate sites of care. The LEQEMBI Copay Assistance Program is not an insurance program. There will be no membership fees. This offer will expire December 31, 2023.

### 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 LEQEMBI Copay Assistance Program, set forth on this enrollment form and also available at [EisaiPatientSupport.com/Leqembi](https://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, TRICARE, or any other federal or state healthcare plan; (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. 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 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 legal representative

\_\_\_\_\_  
Legal representative signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation to patient