LEQEMBI® (lecanemab-irmb) 100 mg/mL
INJECTION FOR INTRAVENOUS USE

Eisai Patient Support

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.

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 ☐ Male ☐ Female
Address	City / State / Zip	
Home phone	Cell phone ☐ OK to leave a message	
Email address	Preferred language ☐ English ☐ Spanish ☐ Other _____	
Preferred contact ☐ Home phone ☐ Cell phone ☐ Email	Best time to call ☐ Morning ☐ Afternoon ☐ Evening	
Caregiver's name	Relationship / Phone number	

Primary insurance information

☐ 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 diagnosis information

Primary ICD-10 code*	Secondary ICD-10 code

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

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

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, fill out the information below.

Name of infusion site or healthcare provider*	Is infusion site primary case contact?* ☐ Yes ☐ No	
Street address*	Send program communications to (check only one)* ☐ Infusion site only ☐ Prescriber only ☐ 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.

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 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. 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. 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*

Eisai Patient Support