REIMBURSEMENT SERVICES ENROLLMENT FORM

for LENVIMA™ (lenvatinib) capsules

Please complete all sections in this form and return to the Eisai Assistance and Support for You (E.A.S.Y.™) program.
Fax: 1-855-246-5192 Phone: 1-855-EISAI-4-U (1-855-347-2448)

Please select the appropriate Specialty Pharmacy

❑ accredo® Specialty Pharmacy Fax: 1-877-247-4847

❑ Biologics Fax: 1-800-823-4506

Physician information

Physician Name:_____

Facility Name:_____

Street Address:_____

City:_____ State:____ Zip:_____

Office Contact:_____

Telephone:_____ Fax:_____

Best Time to Call:_____ Email:_____

State License #:_____

Tax ID #:_____ NPI #:_____

Patient diagnosis information

Diagnosis/ICD Code:_____

Height:_____ Weight:_____

Baseline Blood Pressure:_____

Prescription

❑ Benefit verification only

With confirmation of insurance coverage (or approval for assistance through the E.A.S.Y. program), medication will be shipped via Specialty Pharmacy to the patient's home address unless otherwise indicated by the prescriber:

Product Name: LENVIMA capsules

Dosage/supplied as:

❑ 24 mg, carton with 6 cards (ten 10 mg capsules and five 4 mg capsules per card)

❑ 20 mg, carton with 6 cards (ten 10 mg capsules per card)

❑ 14 mg, carton with 6 cards (five 10 mg capsules and five 4 mg capsules)

❑ 10 mg, carton with 6 cards (five 10 mg capsules per card)

Sig:_____

Refill(s):_____ Quantity:_____

DEA #:_____ Date:_____

Physician declaration

I verify that the above information is complete and accurate to the best of my knowledge and that I have prescribed LENVIMA based on my professional judgment of medical necessity. I authorize Eisai and its affiliated companies or subcontractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient.

I appoint the E.A.S.Y. program solely to convey on my behalf to the pharmacy chosen by or for the above-named patient, the prescription described herein.

I authorize the E.A.S.Y. program to perform a preliminary assessment of insurance verification for the above-named patient, and I further authorize and request that the E.A.S.Y. program provide to me any and all information necessary for completing a Letter of Medical Necessity, as may be required as a result of such insurance verification assessment.

Please sign the appropriate line for the selected dispensing instruction.

Physician Signature:_____ **Date:**_____
(no stamps) (Substitution Permitted)

Physician Signature:_____ **Date:**_____
(no stamps) (Dispense as Written)

Patient information

Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:__ /__ /____ SSN:_____

Daytime Telephone:_____

Evening Telephone:_____

Cell Phone:_____ Best Time to Call:_____

Email:_____

Primary Language:_____

Alternative Contact Name:_____

Alternative Contact Telephone:_____

Allergies:_____

Current Medications:_____

Prescription insurance information

Primary Insurer:_____

Telephone:_____

Subscriber Name:_____

Date of Birth:__ /__ /____ ID#:_____ Group#:_____

Secondary Insurer:_____

Telephone:_____

Subscriber Name:_____

Date of Birth:__ /__ /____ ID#:_____ Group#:_____

❑ Opt in for the E.A.S.Y. $0 Co-pay Card

(Not available to patients enrolled in federal or state healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD, or TRICARE.)

Financial information (for Patient Assistance Program application only)*

Annual household income:$_____

Number of household members dependent on income (include applicant):_____

Source of income: ❑ Job ❑ Family ❑ Public Assistance ❑ SSI/SSDI ❑ Other (Please explain):_____

*Income documentation will be required in order to assess program eligibility (ie, 1040 tax return, SSA-1099, W-2 Form, etc).

Please see the following page for required patient authorization.

LENVIMA™ (lenvatinib) capsules

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Fax: 1-855-246-5192 Phone: 1-855-EISAI-4-U (1-855-347-2448)

Patient authorization for health information and disclosure

I hereby authorize my health care providers and health insurer(s) to disclose to Eisai Inc., its National Account Reimbursement Managers, and other Eisai employees, agents, and service providers involved in the Eisai Assistance and Support for You (E.A.S.Y.™) program (collectively the "Assistance Group") any personal health information ("PHI") about me that is relevant to my treatment with Eisai's drug LENVIMA™ (lenvatinib) capsules so that the Assistance Group may assist me with benefits support in connection with such treatment. The Assistance Group may use my PHI, for example, to communicate with me regarding such treatment and my treatment options, to investigate my insurance coverage, and otherwise help coordinate and assist with treatment support. I understand that once my PHI is disclosed pursuant to this authorization, it may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the E.A.S.Y. program intends to safeguard my PHI and to use and disclose it only for the purposes described herein. Accredo and Biologics may receive compensation from Eisai for certain services, including the collection and provision of data.

I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits and that I may cancel the Authorization at any time by sending a written notice of cancellation to the E.A.S.Y. program either by mail to Post Office Box 29231, Phoenix, AZ 85038, or by fax to 1-855-246-5192. If I do not cancel it, the Authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this Authorization when it is signed.

Name of Patient	Signature	Date
Name of Legal Representative	Signature	Date

If signed by legal representative, describe the nature of his/her relationship with the patient:

Patient acknowledgment (for Patient Assistance Program application only)

I understand that completing this form does not ensure that I will qualify for the Eisai Patient Assistance Program ("PAP"). I represent that the information provided in this enrollment form is complete and accurate. I agree to notify and shall be responsible for notifying the program administrator for the PAP if I obtain coverage through another source or if I no longer meet the income criteria for the PAP. 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.

Name of Patient	Signature	Date
Name of Legal Representative	Signature	Date

If signed by legal representative, describe the nature of his/her relationship with the patient:

Please be sure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without the applicant's signatures.

Eisai cannot guarantee payment of any claim. Coding, coverage, and reimbursement may vary significantly by payer, plan, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. For additional information, customers should consult with their payers for all relevant coding, reimbursement, and coverage requirements. It is the sole responsibility of the provider to select the proper code and ensure the accuracy of all claims used in seeking reimbursement. All services must be medically appropriate and properly supported in the patient medical record.

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