Eisai Fycompa® (perampanel) CIII Patient Assistance Program Application

6501 Weston Parkway, Suite 370, Cary, NC 27513 Phone: (855) EISAI -4-U or (855-347-2448)

Please complete page 2 of this from and fax to: (888) 668-8136

The patient has elected to enroll in the Eisai Fycompa® (perampanel) CIII PAP program. Please read and complete the application form in its entirety. Once eligibility has been determined you will be notified. Completion of this form and application does not guarantee enrollment.

INSTRUCTIONS: How to complete the enrollment form

OVERVIEW

1. Please write legibly and complete all sections to prevent delays.
2. Once completed, forward the completed form to the address or fax indicated above.
3. If the patient is eligible to participate in the Eisai Fycompa® (perampanel) CIII Patient Assistance Program, an acceptance letter will be mailed to the patient and faxed to the physician.
4. If the patient is not eligible for the Eisai Fycompa® (perampanel) CIII Patient Assistance Program, a denial letter will be mailed to the patient and faxed to the physician.
5. Enrollment in the Eisai Fycompa® (perampanel) CIII Patient Assistance Program is valid for one year. After one year, a new application must be submitted.

PRESCRIBING PRACTITIONER INFORMATION

- ❐ Physician must fill out office information completely including telephone and fax number.
- ❐ P.O. Box addresses will not be accepted.
- ❐ Physician must supply a valid DEA or NPI number.

PRESCRIPTION INFORMATION

- ❐ Physician must select a Strength and supply a Quantity.
- ❐ Be sure the Physician signs and dates this section, this enrollment cannot be processed without a Physician's signature.

PATIENT INFORMATION AND ELIGIBILITY

- ❐ To qualify for the program, the patient must be a US Resident.
- ❐ P.O. Box addresses will not be accepted.

INSURANCE INFORMATION

- ❐ Attach a copy of insurance cards, if available.

FINANCIAL INFORMATION

- ❐ Financial documentation is required. Acceptable forms of documentation include federal tax return, social security benefit statement, one month's worth of paycheck stubs, unemployment or disability statements.
- ❐ Household size must be selected.

APPLICANT DECLARATION

- ❐ Be sure the applicant signs and dates this section, this enrollment can not be processed without a patient's signature.

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Prescribing Practitioner Information

Practitioner Name: ______________________ Phone #: (______) ______________________

Office Mailing Address: ______________________ Fax #: (______) ______________________
(street address only, no P.O. boxes)

City: ______________ State: ______ ZIP: ________ Site Name: ______________________

DEA and State License #: ______________________ NPI #: ______________________

Prescription Information

❒ Fycompa® (perampanel): Strength: ❒ 2mg ❒ 4mg ❒ 6mg ❒ 8mg ❒ 10mg ❒ 12mg

Quantity: ______________________ Is this a dosage increase from previous order? ❒ Yes ❒ No

Indication: FYCOMPA (perampanel) is a prescription medicine used with other medicines to treat partial-onset seizures with or without secondarily generalized seizures and primary generalized tonic-clonic seizures in people with epilepsy who are 12 years of age and older.

I certify that the information provided in this application is complete and accurate and that the product ordered hereunder is medically indicated for this patient. I understand eligibility under this Program is subject to Eisai Inc.'s approval and the patient's continuing compliance with all eligibility requirements, as set by Eisai Inc. from time to time. I agree to allow Eisai, or its authorized agent(s), to review the medical, financial and insurance records for this patient at any time 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.

LICENSED PRACTITIONER SIGNATURE (NO SIGNATURE STAMPS, PLEASE) DATE

Patient Information and Eligibility

Name: ______________________ Date of Birth: ______________________

Office Mailing Address: ______________________ Phone #: (______) ______________________
(street address only, no P.O. boxes)

City: ______________ State: ______ ZIP: ________ Email: ______________________

If you are unavailable when we call, may we leave a message including a prescription name? ❒ Yes ❒ No

1. Is the patient a U.S. resident? ❒ Yes ❒ No
2. Does the patient have prescription coverage with any of the following:
   Medicare Part D ❒ Yes ❒ No **(If yes, include a copy of insurance card)**
   Private Insurance (HMO, PPO, etc) ❒ Yes ❒ No **(If yes, include a copy of insurance card)**
   Government Insurance (Medicaid, Veteran's Administration, state or local programs, etc) ❒ Yes ❒ No **(If yes, include a copy of insurance card)**
   Are you currently enrolling in Medicaid? ❒ Yes ❒ No
   Insurance Name: ______________________ Member ID #: ______________________
   Insurance Phone #: (______) ______________________ Group #: ______________________
3. What is the monthly HOUSEHOLD INCOME? $__________ monthly
   Financial documentation is required for the patient to receive assistance through this program. Acceptable forms of income documentation include federal tax return, social security benefit statement, unemployment or disability statement, one month of paycheck stubs. You may be asked to provide a copy of government issued identification (e.g., driver's license, military ID, passport, etc).
4. How many people, including the patient, live in the household (please circle one)? 1 2 3 4 5 6+

Informed Consent and Authorization for Use and Disclosure of Health Information for Patient Assistance Program

I understand that completing this form does not ensure that I will qualify for the Eisai Pathways Assistance Program ("Program"). I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Program if I obtain coverage through another source or if I no longer meet the income criteria for the Program. I authorize my healthcare provider to disclose medical information and related information to Eisai Inc., and its affiliated companies and subcontractors, including CareNet and TrialCard (the "Program Administrator") (collectively "Company"), and I authorize Company to obtain and disclose information as deemed necessary to verify the accuracy and completeness of this application and to provide services available through the Program. I also authorize Company to release medical information and related information to the Centers for Medicare and Medicaid Services ("CMS") for purposes of administering the Program. I understand that personal identifying information provided on this form will be available to Company and its agents for the purpose of administering the Program. I understand that Company reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program. If I decide to terminate my authorization for my health care providers and my insurers to disclose my information to Company, I shall notify Company in writing at Eisai Banzel Patient Assistance Program, 6501 Weston Parkway, Suite 370, Cary, NC 27513 that I no longer provide such authorization which termination shall be effective upon Company's receipt of such notification. I understand that I have a right to obtain a copy of the information my health care providers or insurers have provided to Company upon request to Company. I understand that I may decline to sign this form and decline being considered for the Program. I understand that signing this form does not affect the way my health care providers or insurer will provide me with their respective services.

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

Please see the Important Safety Information including the Boxed WARNING and full Prescribing Information.