LENVIMA® (lenvatinib) capsules | 10 mg and 4 mg

Eisai Patient Support

Eisai Patient Support Enrollment Form

Phone: 1-866-61-EISAI (1-866-613-4724)
Fax: 1-855-246-5192
Monday–Friday: 8 AM–8 PM ET
www.eisaipatientsupport.com/lenvima

Instructions for completion - Eisai Patient Support offers two options for enrollment

Option 1: Complete this form

- Fax completed form and both sides of the patient's insurance card(s) to 1-855-246-5192
- Please select support offerings for which the patient will be evaluated. The patient will not be evaluated for support offerings not selected on this form
- Both the prescriber and patient **must sign the form**

OR

Option 2: Send an ePrescription to Eisai Patient Support Pharmacy

- Send an electronic prescription for LENVIMA directly to Eisai Patient Support Pharmacy, which will initiate the enrollment process into Eisai Patient Support. Eisai Patient Support Pharmacy is categorized as a retail pharmacy in EMR/EHR systems and is located at 2730 S. Edmonds Lane, #400A, Lewisville, TX 75067; the e-Prescribe ID number is 5942176.

Patients may sign the form electronically by visiting www.lenvimaconsent.com.

Program offerings - Providers, please select all the programs you'd like your patients to receive, and follow the instructions listed

☐ **Request an ARM**

Access & Reimbursement Managers (ARMs) support patients' access to prescribed Eisai products by providing relevant information and addressing provider questions regarding insurance coverage, coding, reimbursement, and patient access issues.

☐ **Benefits Investigation**

Helps patients understand their coverage for LENVIMA

Provider: Complete pages 1, 2, and 4
Patient: Sign top of page 4 (*Patient Authorization for Use and Disclosure of Health Information* section)

☐ **Patient Assistance Program (PAP)**

Provides LENVIMA at no cost to eligible patients with financial need

Provider: Complete entire form
Patient: Sign both places on page 4 (*Patient Authorization for Use and Disclosure of Health Information* and *Patient Assistance Program Patient Acknowledgment* sections)

☐ **LENVIMA Welcome Kit**

Includes key LENVIMA educational materials and helpful resources for patients receiving therapy

Provider: Complete pages 1 and 4. No physician signature required.
Patient: Sign top of page 4 (*Patient Authorization for Use and Disclosure of Health Information* section)

Patient information

ALL FIELDS REQUIRED

Patient Name		**Date of Birth**	**Gender** ☐ Male ☐ Female
Street Address		**City**	**State** / **Zip**
Patient Phone Number	**Cell Phone Number**	**Email**	
Alternate Contact Name	**Relationship to Patient**	**Primary Language**	
Alternate Contact Home Phone Number	**Alternate Contact Cell Phone Number**	**Preferred Contact** ☐ Home ☐ Cell ☐ Email	

Patient insurance information

ALL FIELDS REQUIRED

1

Primary Medical Insurance	**Insurance Phone Number**	**Policy ID #**
BIN	**PCN**	**Group #**
Policyholder Name		**Policyholder Date of Birth**

Primary Insurance Information

☐ No insurance ☐ Medicare ☐ Medicaid ☐ Commercial/private insurance plan ☐ VA (Veterans Affairs) ☐ Other _____

2

Secondary Medical Insurance	**Telephone Number**	**Policy ID #**
BIN	**PCN**	**Group #**
Policyholder Name		**Policyholder Date of Birth**

Secondary Insurance Information

☐ No insurance ☐ Medicare ☐ Medicaid ☐ Commercial/private insurance plan ☐ VA (Veterans Affairs) ☐ Other _____

If available, please provide front & back copies of the patient's insurance card when submitting this form.

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Physician information

*REQUIRED FIELD

Physician Name*	**Site/Facility Name**		
Street Address*	**City***	**State***	**Zip***
Office Contact	**Phone Number***		
Fax	**Office Email**		
State License #*	**Tax ID #***	**NPI #***	

Prescription

Medication will be shipped via specialty pharmacy to the patient's home address unless otherwise indicated by the prescriber

Patient Name	**Date of Birth**	**Weight**
Medication Name LENVIMA capsules	**Diagnosis/ICD Code**	

- LENVIMA is available in 4-mg and 10-mg capsules
- LENVIMA capsules are supplied in cartons containing 6 cards. Each card contains a 5-day supply of LENVIMA
- **Please check box for medication strength (required)**

Dose	Daily Capsules in Blister Card	Quantity for 30-Day Supply
☐ **24 mg**	10 mg, 10 mg, 4 mg	**#60** caps of 10 mg; **#30** caps of 4 mg
☐ **20 mg**	10 mg, 10 mg	**#60** caps of 10 mg
☐ **18 mg**	10 mg, 4 mg, 4 mg	**#30** caps of 10 mg; **#60** caps of 4 mg
☐ **14 mg**	10 mg, 4 mg	**#30** caps of 10 mg; **#30** caps of 4 mg
☐ **12 mg**	4 mg, 4 mg, 4 mg	**#90** caps of 4 mg
☐ **10 mg**	10 mg	**#30** caps of 10 mg
☐ **8 mg**	4 mg, 4 mg	**#60** caps of 4 mg
☐ **4 mg**	4 mg	**#30** caps of 4 mg

Sig: _____

Quantity: _____ Refills: _____ Current list of medications: _____

Physician Declaration

The provided information is complete and accurate to the best of my knowledge. I have prescribed LENVIMA based on my independent professional judgment of medical necessity and have taken into account relevant patient safety considerations and the full prescribing information.

Physician Signature: _____ Date: _____

(no stamps)

Prescriber: Please note that you may be asked to provide a separate prescription to comply with state pharmacy law.

Pharmacy

Eisai Patient Support Pharmacy

2730 S. Edmonds Lane, #400A, Lewisville, TX 75067

NCPDP: 5942176 **NPI:** 1861259194 **Hours of operation: M-F:** 8 AM-8 PM ET

Note: HCP can send an electronic prescription for LENVIMA to Eisai Patient Support Pharmacy to initiate enrollment into Eisai Patient Support

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Patient use

Patient authorization for use and disclosure of health information

By signing this Authorization, I authorize each of my physicians, 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 LENVIMA (collectively, the "Program") so that the Program may take the following steps to provide me with support offerings ("Support"):

I. Process my enrollment (or re-enrollment, as applicable) and determine my eligibility for the Program's financial assistance and copay assistance, including benefit verifications and prior authorizations support,

II. Provide me with the Program's financial assistance Support and copay assistance Support,

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 Support 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,

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.

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Patient use (cont'd)

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 Support 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 1-855-246-5192, or calling 1-866-613-4724. 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

Name of Patient or Patient Representative _____ Patient or Patient Representative Signature _____ Date _____

Patient Representative Relationship to Patient _____

Patient Assistance Program Patient Acknowledgment

I understand that completing this form does not ensure that I will qualify for PAP. I certify that the information provided in this enrollment form is complete and accurate. I agree to notify Eisai Patient Support if I obtain coverage through another source or if I no longer meet the income criteria for the PAP. I agree that I will not seek reimbursement for or credit from any insurer, health plan, or government program with respect to this prescription. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. 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.

Verification of income will be required in order for EPS to assess program eligibility. By signing below, I authorize Eisai Inc. and its service providers administering the Patient Assistance Program (collectively, "Eisai") to obtain financial information from my credit profile or other financial information from Experian Income View. I understand that Eisai needs, and I agree that Eisai may use, this financial information to determine my financial eligibility to participate in Eisai's Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner if so requested.

Name of Patient or Patient Representative _____ Patient or Patient Representative Signature _____ Date _____

Patient Representative Relationship to Patient _____

Note: Patients can visit www.lenvimaconsent.com to provide digital signatures needed on this form.