

EISAI ASSISTANCE PROGRAM - ONCOLOGY

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line. Return this completed confidential application and prescription to:

Eisai Assistance Program
PO Box 4133
Gaithersburg, MD, MD 20885-4133
Telephone: (866) 613-4724
Fax: (866) 573-4724

PATIENT INFORMATION

Patient Name: _____
SS#: _____ / _____ / _____ Date of Birth: _____
Patient Language: English Spanish Other _____
Street Address: _____
City, State, Zip: _____
Home Telephone: (____) _____ Work Telephone: (____) _____

COVERAGE AND INSURANCE

If you do not have insurance, please indicate "No Insurance" on the first line.

Primary Insurance

Health Insurance Company: _____
Telephone: (____) _____ Provider ID Number: _____
Policy ID Number: _____ Group Number: _____
Subscriber Name: _____ Date of Birth: _____
Does this policy cover prescription drugs? YES NO
Do you have any **secondary insurance**, including **Medicare**?
 YES No

(If yes, please provide name, telephone number, and policy number)

Have you applied to **Medicaid**? YES NO

If YES, date of application: _____

Are you eligible? YES NO

If not eligible, reason for denial: _____

FINANCIAL INFORMATION

Current annual household income \$ _____
Source of income: Job Family
 Public Assistance (SSI/SSDI)
Number of household members dependent on income stated above
(include applicant) _____
Other (Please explain): _____

APPLICANT DECLARATION**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 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 (collectively "Company"), including Covance Market Access Services Inc. (the "Program Administrator") and Express Scripts Specialty Distribution Services, 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 Assistance Program, PO Box 4133, Gaithersburg, MD 20885-4133 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.

Signature of Patient or Legal Representative Date

Printed Name of Patient or Printed Name of Legal Representative and Relationship to Patient

PHYSICIAN INFORMATION

This section is to be completed by the physician only.

Patients who qualify for assistance will receive free product shipped to the physician's office/clinic. Please attach the patient's prescription to this application.

Physician Name: _____
Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
DEA #: _____ State License #: _____
Tax ID Number: _____ NPI #: _____

Office Contact Name _____

(e.g. nurse, social worker or other representative we should contact regarding this patient.)

Prescribing Information:

Eisai Drug Requested: _____ Dosage _____

What is the patient being treated for? _____

Patient Weight: _____ kg

Physician Certification:

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 further certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party shall be charged for such product. Additionally, no units of product will be submitted for Medicare, Medicaid, or any public or private third party reimbursement, or returned for credit. 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.

Signature Date

As part of your patient's eligibility, you will be asked to periodically verify continued use of the requested Eisai product and resubmit a current prescription.