



EISAI ASSISTANCE PROGRAM
Patient Portion – Page 1 of 2

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A." Please fax or mail the completed application to:

Eisai Assistance Program
PO Box 29231, Phoenix, AZ 85038
Fax: (866) 272-8805 Phone: (866) 613-4724

Section 1 – Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

City: _____ State: _____ ZIP: _____

Daytime Phone: () _____ Evening Phone: () _____

Section 2 – Patient Health Insurance Information

Do you have insurance? YES NO If yes, complete the table below (include all insurance policies).

Have you ever applied for Medicaid? YES NO Date of application: _____

If you applied and were not eligible, please provide reason: _____

| | Medicare | Medicaid | Commercial/Other |
|-------------------------------|----------|----------|------------------|
| Insurance company name | | | |
| Policy number | | | |
| Group number | | | |
| Telephone number | | | |
| Policy holder's name | | | |
| Policy holder's date of birth | | | |

Section 3 – Patient Financial Information

Total number in household (applicant and dependents): _____

Total annual nonreimbursed medical expenses: \$ _____

Please list total current annual household income for each item listed below. Include all income of persons living in the household. Total Annual Income: \$ _____

| | | | |
|----------------------------|----------|-----------------------------------|----------|
| Salary/Wages | \$ _____ | Supplemental Social Security | \$ _____ |
| Pensions | \$ _____ | Social Security Disability Income | \$ _____ |
| Social Security Retirement | \$ _____ | Other | \$ _____ |

Patient Authorization 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 McKesson Specialty Arizona 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 29231, Phoenix, AZ 85038 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



EISAI ASSISTANCE PROGRAM
Physician Portion – Page 2 of 2

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A."

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PO Box 29231, Phoenix, AZ 85038
Fax: (866) 272-8805 Phone: (866) 613-4724

Patients who qualify for assistance will receive free product shipped to location of choice.

Please attach the patient's prescription to this application. As part of your patient's eligibility, you and/or your patient will be asked to periodically verify continued use of FRAGMIN and resubmit a current prescription as needed.

Section 4 – Physician Information

Physician Name: _____ NPI Number: _____
 Site/Facility Name: _____ Contact Name: _____
 Site/Facility Address: _____ City: _____ State/ZIP: _____
 Phone Number: (____) _____ Fax Number: (____) _____
 DEA Number: _____ DEA Expiration Date: _____
 State License: _____ State License Expiration Date: _____

Section 5 – Shipping Information

Name: _____ Ship Attention: _____
 Ship to Address: _____ City: _____ State/ZIP: _____
 Phone Number: (____) _____ Fax Number: (____) _____

Section 6 – Prescribing Information and Product Type (Please attach prescription)

Dosage: _____ Patient Weight: _____ kg

Product Requested/Administered

| Single-Dose Prefilled Syringes (Packs of 10) # of packs | Multiple-Dose Vials | Quantity |
|--|--|----------|
| <input type="checkbox"/> 0.2 mL (2500 IU/0.2 mL) NDC 62856-0250-10 _____ | <input type="checkbox"/> 3.8 mL (25,000 IU/mL) NDC 62856-0251-01 _____ | |
| <input type="checkbox"/> 0.2 mL (5000 IU/0.2 mL) NDC 62856-0500-10 _____ | <input type="checkbox"/> 9.5 mL (10,000 IU/mL) NDC 62856-0102-01 _____ | |
| <input type="checkbox"/> 0.3 mL (7500 IU/0.3 mL) NDC 62856-0750-10 _____ | | |
| <input type="checkbox"/> 1 mL (10,000 IU/mL) NDC 62856-0101-10 _____ | | |
| <input type="checkbox"/> 0.5 mL (12,500 IU/mL) NDC 62856-0125-10 _____ | | |
| <input type="checkbox"/> 0.6 (15,000 IU/mL) NDC 62856-0150-10 _____ | | |
| <input type="checkbox"/> 0.72mL (18,000 IU/mL) NDC 62856-0180-10 _____ | | |

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.

Physician Signature: _____ Date: _____



Eisai Assistance Program for Fragmin
INSURANCE VERIFICATION FORM
 Please fax completed form to (866) 272-8805

Hours: Monday - Friday
 Phone: 866-61-EISAI
 8:00 a.m. – 8:00 p.m. EST

INSTRUCTIONS

For Insurance Verification/Pre-Certification

1. Please complete all sections of the form
2. Eisai Assistance Program for Fragmin will respond by fax to the physician's office within 2 business hours with insurance verification results, if fax request is received before 3:30pm EST

PATIENT INFORMATION (Please print)

U.S. Resident: Yes No Social Security #: -- Phone: --
 Patient Name: _____ Date of Birth: ____/____/____ Gender: M F
 Address: _____ City: _____ State: _____ ZIP: _____
 Employment Status: Employed Unemployed Self-employed Retired

INSURANCE INFORMATION (Please attach a copy of the front and back of patient insurance card, Medicare and/or Medicaid cards)

| PRIMARY COVERAGE | | SECONDARY COVERAGE | |
|-------------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| Insurance Name: | | Insurance Name: | |
| Insurance Phone #: | | Insurance Phone #: | |
| Policy #: | | Policy #: | |
| Group #: | | Group #: | |
| Policy Holder's Name: | | Policy Holder's Name: | |
| Policy Holder's DOB: | | Policy Holder's DOB: | |
| Policy Holder's SSN: | | Policy Holder's SSN: | |
| Employer: | | Employer: | |
| MD's Provider # (if applicable): | In Network? Y N (circle one) | MD's Provider # (if applicable): | In Network? Y N (circle one) |

PATIENT CONSENT

The Eisai Assistance Program ("Program") requires us to confirm with you that the patient's consent provides authorization for us to obtain and provide insurance information and for us to contact the insurer and relay patient-related information, e.g., patient's name, date of birth, social security number, diagnosis, insurance information, etc. Does your facility have the patient's valid written authorization on file?

- Yes** if yes, no additional authorization is needed. **No** if no, please have the patient sign a valid written authorization so that you may disclose to the Program information necessary for the Program to provide and obtain information related to this reimbursement issue.

X

Signature of Patient or Patient Representative

Date

Printed Name of Patient OR Legal Representative

(if signed by representative, explain authority to act on behalf of patient) Relationship to Patient

PHYSICIAN/FACILITY INFORMATION (Please print and ensure all ID #s correspond to the GROUP or PROVIDER)

Physician Name: _____ Office Contact: _____
 Facility Name: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Phone: -- Fax: -- PTAN: _____
 Tax ID: _____ State License No: _____ NPI #: _____

DIAGNOSIS/DRUG INFORMATION (Required)

Diagnosis: _____ ICD-9 Code: _____
 Known Allergies? No Yes, please specify: _____

Fragmin® Dosage: Single-Dose Prefilled Syringes

0.2 mL (2500 IU/0.2mL) 0.2 mL (5000 IU/0.2 mL) 0.3 mL (7500 IU/0.3 mL) 1 mL (10,000 IU/mL)
 0.5 mL (12,500 IU/mL) 0.6 mL (15,000 IU/mL) 0.72 mL (18,000 IU/mL)

Multiple Dose Vials

3.8 mL (25,000 IU/mL) NDC # 62856-0251-01
 9.5 mL (10,000 IU/mL) NDC # 62856-0102-01

Prior Therapy: _____

Patient Weight: _____

PHYSICIAN CERTIFICATION

Please indicate that you agree to these terms by signing below. Failure to comply with these terms may mean you (and any patients you treat) will not be eligible to participate in the Eisai Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

➔ Physician's Signature: _____ Date: _____

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.