THE EISAI ASSISTANCE PROGRAM

Eisai Patient Assistance Program Enrollment Form for Fragmin®
P.O. Box 29231 Phoenix, AZ 85038
Phone: 866-61-EISAI (866-613-4724) Fax: 866-272-8805

Hours: Monday - Friday
8:00 a.m. – 8:00 p.m. EST

INSTRUCTIONS (Please attach prescription)

For Patient Assistance Program

1. Please complete all sections of the application and shipment request form. Please fax or mail the completed forms and prescription to the fax or address indicated above.
2. If the patient is eligible to participate in the Eisai Patient Assistance Program, we will send an acceptance letter to the physician and patient. Free product will be shipped as indicated on the shipment request form (page 2) typically within 24-72 hours of approval.
3. If the patient is not eligible for the Eisai Patient Assistance Program, a denial letter will be sent to the physician and patient.
4. Enrollment in the Eisai Assistance Program is valid for 6 months and is for out-patient use only. After 6 months, a new application must be submitted.

SECTION 1. PATIENT INFORMATION (Please print)

U.S. Resident: ❒ Yes ❒ No Social Security #: _____ - _____ - _____ Phone: _____ - _____ - _____

Intended Product Use: ❒ Inpatient **(not eligible for patient assistance)** ❒ Outpatient

Patient Name: _____ Date of Birth: _____/_____/_____ Gender: M ❒ F ❒

Address: _____ City: _____ State: _____ ZIP: _____

SECTION 2. PHYSICIAN/FACILITY INFORMATION (Please print)

Physician Name: _____ NPI #: _____

Facility Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ Office Contact: _____

SECTION 3. PHYSICIAN CERTIFICATION

I certify that the information provided in this application is complete and accurate. I further certify that all units of any product shipped to me pursuant to this application will (a) 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 or (b) replace product previously supplied to the above-named patient pursuant to the presumptive approval process, and that no patient or third party was or will 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 atient's receipt of any product(s) provided to him or her through the Program.

Physician's Signature: _____ Date: _____

SECTION 4. INSURANCE INFORMATION (Please attach a copy of insurance cards, if available)

Does the applicant have insurance? ❒ Yes ❒ No *If yes, complete the table below (include all insurance policies)*

Insurance Information	Check One	Policy Number	Phone Number
Private Drug Coverage	❒ Yes ❒ No		
Medicaid	❒ Yes ❒ No		
Medicare	❒ Yes ❒ No		
Medicare Part D	❒ Yes ❒ No		

SECTION 5. FINANCIAL INFORMATION (Financial documentation may be required for the patient to receive assistance through this program)

Total Gross Household Monthly Income $_____

Included but not limited to Salary, Wages, Pension, Retirement, Social Security, Social Security Disability, Alimony, Child Support, Unemployment and Worker's Comp.

Please provide the amount you have spent so far this year (January-Current Month) on your non-reimbursed medical and prescription expenses below.

Total Current Year to Date Non-Reimbursed Medical Expenses	Total Current Year to Date Out-of-Pocket Prescription Costs
$	$

Number of household members dependent on income stated above (including applicant): 1 2 3 4 5 6 7 8 (Circle One)

SECTION 6. APPLICANT DECLARATION

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

I am voluntarily submitting this form to apply for benefits under the Eisai Patient Assistance Program ("Program"). I understand that completing this form does not ensure that I will qualify for assistance under the Program. I represent that the information provided is complete and accurate. I agree to notify the Program Administrator if I obtain coverage through another source. 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 US Bioservices Corporation on behalf of itself and its subsidiaries and its affiliate, Integrated Commercialization Solutions, Inc. (together, "US Bioservices"), to verify the accuracy and completeness of this application and to provide services available through the Program. I also authorize Company to release 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 Patient Assistance Program, Post Office Box 29231, Phoenix, AZ 85038. 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.

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

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Shipment Request form for Fragmin®

This page MUST be completed to fulfill shipment requests - Subject to Patient Eligibility

Instructions for completing this shipment request form:

- ◆ Confirm patient eligibility with Eisai Patient Assistance Program
- ◆ Provide patient name and date of birth
- ◆ Provide facility/physician office contact information, state licensure/DEA and signature
- ◆ Determine appropriate shipment option(s):

1. You have dispensed product to your eligible patient in your facility and need drug replacement, please complete Section 1.
2. You are requesting product for your patient's future therapy and wish to initiate facility/physician office shipments, please complete Section 2 and attach a prescription.
3. You are requesting product for your patient's future therapy, and wish for patient to receive shipments, please complete Section 3 and attach a prescription, written for full future regimen.
4. You have dispensed product to your patient as well as need to request product for your patient's future therapy; please complete Section 1 and 3 and attach a prescription, written for full regimen.

Patient Name: _____ **Date of Birth:** _____/_____/_____

❒ **Hospital/Facility:** Provide Facility State License or DEA #_____ Facility State License or DEA Expiration Date _____ ❒ **Physician:** Provide Physician State License or DEA# _____ Physician State License or DEA Expiration Date _____

State License or DEA is required for shipping verification.

Product typically ships within 24-72 hours of patient assistance approval. **Please provide the corresponding shipping address(s) below. ALL information must be provided prior to product shipment.**

Physician Name: _____ Ship ATTN: _____

Facility Name: _____

Ship-to Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____

Physician's Signature: _____ Date: _____

SECTION 1. SHIP REPLACEMENT PRODUCT TO HOSPITAL/FACILITY OR PHYSICIAN OFFICE

Single-Dose Prefilled Syringes		Quantity 1 = 1 syringe
❒ 0.2 mL (2500 IU/0.2 mL)	NDC 62856-0250-10	_____
❒ 0.2 mL (5000 IU/0.2 mL)	NDC 62856-0500-10	_____
❒ 0.3 mL (7500 IU/0.3 mL)	NDC 62856-0750-10	_____
❒ 1 mL (10,000 IU/1 mL)	NDC 62856-0101-10	_____
❒ 0.5 mL (12,500 IU/0.5 mL)	NDC 62856-0125-10	_____
❒ 0.6 mL (15,000 IU/0.6 mL)	NDC 62856-0150-10	_____
❒ 0.72 mL (18,000 IU/0.72 mL)	NDC 62856-0180-10	_____

Multiple-Dose Vials		Quantity 1 = 1 vial
❒ 95,000 IU/3.8 mL (25,000 IU/1 mL)	NDC 62856-0251-01	_____
❒ 95,000 IU/9.5 mL (10,000 IU/1 mL)	NDC 62856-0102-01	_____

SECTION 2. SHIP PRODUCT TO HOSPITAL/FACILITY OR PHYSICIAN OFFICE

❒ Please check if you are requesting product for patient's continuing therapy and attach a prescription. If patient is approved, call 866-61-EISAI for subsequent refills prior to treatment.

SECTION 3. SHIP TO PATIENT

◆ **Please attach patient prescription written for full treatment regimen. Patient will be contacted prior to shipment to coordinate delivery.**

Ship-to Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ - _____ - _____ Alternate Phone Number: _____ - _____ - _____

Please list any patient allergies: _____ ❒ Not Known

Please list the names of other medications the patient is currently taking: _____ ❒ None