EISAI PATIENT ASSISTANCE PROGRAM FOR DAYVIGO® (LEMBOREXANT) CIV — PATIENT ENROLLMENT FORM

PHONE: 866-349-3026 Monday through Friday 8 AM to 8 PM ET | FAX: 844-737-3493

Please complete all sections in this form and fax to 844-737-3493. Incomplete information may cause a delay in processing.

PHYSICIAN INFORMATION

Physician Name: ______________________ Facility Name: ______________________

Street Address: ______________________ City: ______________ State: ______ ZIP Code: ________

Office Contact Name: ______________________ Office Contact Phone: (_____) _____-__________

Office Phone: (_____) _____-__________ Office Fax: (_____) _____-________ Tax ID#: ______________ NPI #: ______________

Email: ______________________ DEA#: ______________________

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Street Address: ______________________ City: ______________ State: ______ ZIP Code: ________

Date of Birth: ____ /____ /_______ SSN: ______________ Gender: ❐Male ❐Female Home Phone: (_____) _____-__________ Mobile Phone: (_____) _____-_______

Advocate Contact Name: ______________________ Advocate Contact Phone: (_____) _____-__________

Primary Language: ______________________ Email: ______________________

PATIENT INSURANCE INFORMATION (PLEASE INCLUDE FRONT AND BACK COPIES OF EACH INSURANCE CARD OR COMPLETE THIS SECTION)

For Commercially Insured Patients

Medical Insurance Name: ______________________ Insurance Plan Phone: (_____) _____ - ______________

Member ID #: ______________ Group #: ______________ Policyholder Name: ______________________

Relationship to Patient: ______________________ Policyholder Date of Birth: ____ /____ /________

Pharmacy Benefit Manager (PBM) Name: ______________________ PBM Phone: (_____) _____-__________

Rx Policy #: ______________ Rx Group #: ______________ Rx BIN #: ______________ Rx PCN #: ______________

❐ Patient has multiple Rx plans ❐ Copies of Insurance Cards attached

For Patients Enrolled in Medicare Part D

Medical Insurance Name: ______________________ Insurance Plan Fax: (_____) _____-__________

Member ID #: ______________________ Rx BIN #: ______________ Rx PCN #: ______________

PATIENT DIAGNOSIS INFORMATION

Diagnosis: ______________________ ICD-10 Code: ______________________

MEDICATIONS AVAILABLE

DAYVIGO (lemborexant) CIV: **Tablet:** 5mg 10mg

PRESCRIPTION INFORMATION

Product Requested: ______________ Strength: ______________ Quantity: ______________ Refills: __________

Directions: ______________________ Is this a dosage increase? __________

Allergies: ______________________ Concurrent Medications: ______________________

Prescriber: Prescriptions should be conveyed in accordance with state laws including specific forms, e-prescribing, and quantity limitations.
This form should not be utilized if non-conforming to regulations in your state.

Physician signature required on next page ▶

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PHYSICIAN DECLARATION (NO SIGNATURE STAMPS, PLEASE)

STOP

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

STOP

Signature Required for Enrollment ▶ Licensed Practitioner Signature: ______________________ Date: ____ /____ /_________

DAYVIGO PATIENT ASSISTANCE PROGRAM *(COMPLETE THIS SECTION TO ENROLL INTO THE DAYVIGO PATIENT ASSISTANCE PROGRAM)*

❒ **To Enroll in the DAYVIGO Patient Assistance Program please check here and complete this section**

1. Is the patient a U.S. resident? ❒ Yes ❒ No
2. Annual household income: $ ___________
3. How many people, including the patient, live in the household? __________
4. Is the patient currently enrolling in Medicaid? ❒ Yes ❒ No
5. Is the patient uninsured or functionally uninsured? ❒ Yes ❒ No
   (Patients may be functionally uninsured when their insurance doesn't cover their medication or high deductibles make their medication difficult to afford)

DAYVIGO (LEMBOREXANT) CIV PATIENT ASSISTANCE PROGRAM ADDITIONAL INFORMATION

DAYVIGO PATIENT ASSISTANCE PROGRAM ELIGIBILITY

❒ Patient must be a US Resident

❒ Household size must be indicated

❒ Patients insured by Medicaid, Tricare, VA or other Federal or State healthcare plans are not eligible for patient assistance

If the patient is determined eligible for the DAYVIGO Patient Assistance Program, an acceptance letter will be faxed to the physician. If the patient is not eligible for the DAYVIGO Patient Assistance Program, a denial letter will be faxed to the physician. Enrollment in the DAYVIGO Patient Assistance Program is valid for up to one year, at which time a new enrollment form must be submitted for an eligibility determination of continued need. Completion of the Patient Enrollment Form does not guarantee enrollment into the DAYVIGO Patient Assistance Program. Please notify us of any change in patient insurance status.

PATIENT AUTHORIZATIONS

❒ Be sure the applicant signs and dates BOTH the Patient Authorization for Health Information and Disclosure, and the Patient Assistance Program Acknowledgment

Please write legibly and complete all sections to prevent delays. Fax the completed form to 844-737-3493.

PATIENT ASSISTANCE PROGRAM ACKNOWLEDGMENT

STOP

I understand that completing this form does not ensure that I will qualify for the DAYVIGO Patient Assistance Program. I represent that the information provided in this enrollment form is complete and accurate. I agree to notify the DAYVIGO Patient Assistance Program 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. 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.

STOP

If Enrolling in PAP, Please Sign Here ▶ Patient or Legal Guardian Signature: ______________________ Date: ____ /____ /_________

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PATIENT AUTHORIZATION FOR HEALTH INFORMATION AND DISCLOSURE

Please be sure the applicant signs and dates as indicated. This enrollment cannot be processed without the applicant's signature.

I authorize my health care providers and health insurer(s) to disclose to Eisai Inc., its employees, agents, and service providers involved in the DAYVIGO Patient Assistance Program, (collectively, the "Program") any personal health information ("PHI") about me that is relevant to my treatment with DAYVIGO so the Program may assist me with the patient assistance program in connection with such treatment. I authorize the Program to use my PHI and to disclose it to my health care providers and health insurer(s) for the foregoing purposes. I understand that once my PHI is disclosed pursuant to this authorization, it may no longer be protected by federal law and could be re-disclosed to others, but I also understand that the Program intends to use and disclose my PHI only as described herein. I understand that I do not need to sign this authorization in order to receive health care treatment or insurance benefits, and that I may cancel the authorization at any time (other than with respect to uses and disclosures that by then have already been made in reliance on the authorization) by sending a notice of cancellation to the DAYVIGO Patient Assistance Program by fax to 844-737-3493. If I do not cancel it, the authorization will remain in effect for one year from the date of my signature below. I understand that I have a right to receive a copy of this authorization when it is signed.

STOP Signature Required for Enrollment ▼ **STOP**

Name of Patient: ______________________ Signature: ______________________ Date: ____/____/______

Name of Legal Representative: ______________________ Signature: ______________________ Date: ____/____/______

Relation to Patient: ______________________

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