THE EISAI ASSISTANCE PROGRAM

Eisai Assistance Program
INSURANCE VERIFICATION FORM
Please fax completed form to 1-855-246-5192

Phone: 866-61-EISAI (866-613-4724)

INSTRUCTIONS

1. Complete all sections of this form for Insurance Verification
2. Fax completed form to 1-855-246-5192

DRUG/DIAGNOSIS INFORMATION (Required)

Eisai Drug Requested: ☐ **HALAVEN®** (eribulin mesylate) injection

Please list prior therapies: ____________________

Diagnosis: ____________________ ICD-10 Code(s): ____________________

PATIENT INFORMATION (Please print)

U.S. Resident: ☐ Yes ☐ No Social Security #: ____________________ Phone: ____________________

Patient Name: ____________________ Date of Birth: ______/______/______ Gender: M ☐ F ☐

Address: ____________________ City: ____________________ State: ______ ZIP: ____________

INSURANCE INFORMATION (Attach a copy of the front & back of patient insurance card, prescription drug 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:	
Employer #:		Employer #:	
Payer Specific Provider # or PTAN (if applicable)		Payer Specific Provider # or PTAN (if applicable)	

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 authorization on page 2 so that you may disclose to the Program information necessary for the Program to provide and obtain information related to this reimbursement issue.

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

Physician Name: ____________________ NPI #: ____________________

Facility Name: ____________________

Address: ____________________ City: ____________________ State: ______ ZIP: ____________

Phone: ____________________ Fax: ____________________ Office Contact: ____________________

Tax ID: ____________________ State License No: ____________________

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 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.

PATIENT AUTHORIZATION FOR HEALTH INFORMATION USE AND DISCLOSURE

I hereby authorize my health care providers and health insurer(s) to disclose to Eisai Inc. and its employees, agents, and service providers involved in the Eisai Assistance Program, including the Patient Assistance Program ("PAP") (collectively, the "Program") any personal health information ("PHI") about me that is relevant to my treatment with HALAVEN so that the Program may assist me with investigating and verifying insurance benefits in connection with such treatment. I authorize the Program to use this PHI and to disclose it to my health care providers and health insurer(s) for the foregoing purpose. I also authorize the Program to use my PHI for quality assessment and improvement purposes in providing this service. 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 the PHI only as described herein or as required by law.

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 Eisai Assistance Program either by mail to 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067, or by fax to 1-855-246-5192. If I do not cancel it, the authorization will remain in effect for twenty-five years 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.

______________________	______________________	__________
[Name of Patient]	Signature	Date
______________________	______________________	__________
[Name of Legal Representative]	Signature	Date

If signed by legal representative, describe the nature of his/her relationship with patient:

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