Out-of-Pocket Assistance Program Enrollment Form

To enroll in the Out-of-Pocket Assistance Program, complete this form and mail to the ***JourneyMate Support Program***™ Insurance & Access Specialist, 680 Century Point, Lake Mary, FL 32746 or fax to 1-888-782-6157. Read the Patient Authorization on page 3 and provide a patient signature at the bottom of this page. Patient should retain a copy of this page and page 3 of this form for their records. For assistance or additional information, call 1-844-772-4548, Monday-Friday, 8:00 AM-8:00 PM ET.

1. PATIENT AND INFUSION PROVIDER INFORMATION (*REQUIRED FIELDS)

*NAME (First, MI, Last, Suffix) ____________ *DATE OF BIRTH (MM/DD/YYYY) ____________

*ADDRESS ____________ *CITY ____________ *STATE ______ *ZIP ____________

*CELL PHONE ____________ *HOME PHONE ____________

*PREFERRED NUMBER TO CALL ☐ Cell Phone ☐ Home Phone ☐ Okay to Leave Voicemail *EMAIL ____________

*INFUSION PROVIDER NAME ____________ *PROVIDER PHONE ____________ PROVIDER FAX ____________

PLEASE ANSWER QUESTIONS BELOW FOR ELIGIBILITY DETERMINATION.

1. Do you currently have commercial insurance with prescription coverage for RADICAVA® medication, and your insurance does not cover the entire cost of RADICAVA®?
☐ Yes ☐ No

2. Do you confirm that you are NOT enrolled in, and will NOT seek reimbursement (in whole or in part), from government health insurance (ie, Medicare, Medicaid, VA, DoD, or other federal or state assistance programs)?
☐ Yes ☐ No

3. Do you confirm that you will not seek reimbursement or compensation from any of these programs, including from a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA) or other federal or state assistance programs?
☐ Yes ☐ No

Please read full Eligibility Requirements & Terms and Conditions on page 2.

2. INSURANCE INFORMATION (*REQUIRED FIELDS)

***PRIMARY INSURANCE** ____________

*CARDHOLDER NAME ____________

*GROUP/PLAN NAME ____________

*POLICY # ____________ *GROUP # ____________

*INS. CO. PHONE ____________ *STATE ____________

***PRESCRIPTION DRUG INSURER** ____________

*CARD/BIN # ____________ *PHONE ____________

SECONDARY INSURANCE ____________

CARDHOLDER NAME ____________

GROUP/PLAN NAME ____________

POLICY # ____________ GROUP # ____________

INS. CO. PHONE ____________ STATE ____________

PRESCRIPTION DRUG INSURER ____________

CARD/BIN # ____________ PHONE ____________

3. MARKETING COMMUNICATIONS AND MARKET RESEARCH TEXT MESSAGE OPT-IN

☐ **YES** - I agree to receive updates and information about ALS and treatment options from JourneyMate by SMS text messages. Message frequency varies. Text HELP to 85427 for help. Text STOP to 85427 to end. Message and data rates may apply. By opting in, I authorize JourneyMate to deliver SMS text messages using an automatic telephone dialing system and I understand that I am not required to opt in as a condition of purchasing any property, goods, or services. Read Text Message Terms and Conditions (radicava.com/mobile) and Privacy Policy (mt-pharma-america.com/privacy-policy).

☐ **NO** - I do not agree to receive marketing communications via SMS text messages as described above.

4. PATIENT AUTHORIZATION (Patient must read the Patient Authorization and sign below.)

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Authorization included on Page 3 to participate in the ***JourneyMate Support Program***™ and the Out-of-Pocket Assistance Program. By checking the box and signing below, I certify and acknowledge that I have read, understand, and agree to release my Protected Health Information to Mitsubishi Tanabe Pharma America (as defined) for the purposes described on Page 3.

☐ By checking this box, I agree that my Protected Health Information can be used and disclosed for the marketing communications and market research purposes described on page 3.

PATIENT SIGNATURE ____________ DATE ____________

If patient cannot sign above, patient's Legal Representative must sign below.

PATIENT NAME (Please Print) ____________

LEGAL REPRESENTATIVE NAME (Please Print) ____________

NATURE OF RELATIONSHIP TO PATIENT ____________

By signing on this line, I certify under penalty of perjury that I am the legally authorized representative with authority to sign on behalf of the patient named herein.

LEGAL REPRESENTATIVE SIGNATURE ____________ DATE ____________

WITNESS NAME (Optional) (Please Print) ____________

WITNESS SIGNATURE ____________ ☐ NOTARY

Please see Prescribing Information, including Patient Information for RADICAVA®, also available at radicava.com.

Eligibility Requirements & Terms and Conditions for the Out-of-Pocket Assistance Program

Patients who meet the following eligibility criteria and are enrolled in the Out-of-Pocket Assistance Program may pay as little as $0 per infusion with a $20,000 maximum benefit per calendar year.

- This offer may not be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription.
- You must be a citizen or a permanent resident of the US or its territories, and reside in the US or its territories where co-pay assistance is not prohibited. Offer good only in the US and its territories.
- You must be 18 to 64 years of age and not enrolled in Medicare.
- You must not be enrolled in government health insurance (ie, Medicare, Medicaid, VA, DoD, or other federal or state assistance programs). If you move or switch from commercial insurance to any government health insurance, you will no longer be eligible.
- This program is not valid in states where prohibited by law, taxed, or otherwise restricted.
- Persons residing in Massachusetts, Minnesota, Michigan, and Rhode Island are eligible for out-of-pocket assistance for the cost of the drug only and are not eligible for other types of cost support for administration of the medication.
- You are being treated as an outpatient by a licensed healthcare provider in the US and have been prescribed RADICAVA® (edaravone) by a licensed healthcare provider.
- You currently have private, commercial health insurance with prescription coverage for RADICAVA® medication, and your insurance does not cover the entire cost of RADICAVA®.
- There is no income requirement.
- You must re-enroll annually to remain in the Program. To re-enroll, reverification of your insurance benefits is required to confirm that you continue to meet the eligibility requirements for participation in the Program.
- You are responsible for reporting receipt of co-pay assistance to any insurer, health plan, or other third party who pays for or reimburses any part of the medication or treatment cost using the Out-of-Pocket Assistance Program, as may be required.
- You must not seek reimbursement or compensation, in whole or in part, from government health insurance (including Medicare, Medicaid, VA, DoD, or other federal or state assistance programs), a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).
- You will not in any way report or count the value of the product provided under this Program as true out-of-pocket spending (TrOOP) under a Medicare Part D prescription drug benefit.
- Claims must be submitted in a timely manner. An EOB from patient's private, commercial health insurance must be submitted within 365 days of the date of the EOB for patient to receive out-of-pocket assistance benefit. No EOB may be submitted more than 90 days after the expiration date of the Out-of-Pocket Assistance Program, and the date of service on the EOB must be prior to the program expiration date. The EOB must reflect the patient's out-of-pocket cost for RADICAVA® medication and infusion services and submission of the claim by the patient's physician for the cost of the medication and infusion services.
- This Out-of-Pocket Assistance Program is not health insurance.
- This Out-of-Pocket Assistance Program enables submission of both Pharmacy and Medical benefit claims.
- This offer is limited to one (1) per person during this offering period and is not transferable.
- No membership fees.
- This offer is not conditioned on any past, present or future purchase, including refills.
- Offer expires December 31, 2022. Mitsubishi Tanabe Pharma America, Inc. has the right to modify, alter, or cancel the Out-of-Pocket Assistance Program at any time without prior notification.

Please see Prescribing Information, including Patient Information for RADICAVA®, also available at radicava.com.

Mitsubishi Tanabe Pharma America

PATIENT AUTHORIZATION

My signature on page 1 serves as confirmation that I have read, understand, and agree to the Patient Authorization, to participate in the Out-of-Pocket Assistance Program ("the Program") and the *JourneyMate Support Program*™ and to release my Protected Health Information to Mitsubishi Tanabe Pharma America, Inc. (as defined below), supporting the access program as indicated in this Patient Authorization. I certify that I have read, understand, and comply with the full Eligibility Requirements & Terms and Conditions on page 2.

My signature on this Out-of-Pocket Assistance Program Enrollment Form (the "Form") for RADICAVA® (edaravone) serves as confirmation that I authorize each of my physicians and pharmacists, including any specialty pharmacy and/or home infusion provider, which receives my prescription for RADICAVA® and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to use and disclose my Protected Health Information, including, but not limited to, medical records and history, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, insurance plan and/or group numbers (together, "Protected Health Information") to Mitsubishi Tanabe Pharma America, Inc., its affiliated companies, agents and representatives (together, "Mitsubishi Tanabe Pharma America" or "MTPA"), including providers of alternate sources of funding for prescription drug costs, and vendors providing relevant patient education programs and other service providers supporting product access programs for Healthcare Providers and patients for the purposes described below.

Product Access Services Enrollment

I specifically authorize MTPA to receive, use, and disclose my Protected Health Information for the following purposes: (i) to enroll me in, and contact me and/or the person legally authorized to sign on my behalf, about the ***JourneyMate Support Program*™** services, including potential enrollment in the Out-of-Pocket Assistance Program if I am an eligible, commercially insured patient with insurance coverage for RADICAVA®, or Patient Assistance Program, if I have no insurance and meet eligibility requirements; (ii) to provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to RADICAVA®; and to contact me about enrolling in a relevant patient education program; (iii) to provide access support education, including contacting my Healthcare Providers regarding my coverage for RADICAVA®; (iv) to assist with analyses related to the quality, efficacy, and safety of RADICAVA® and patient access to and treatment compliance with RADICAVA®; and (v) to enhance and improve the product access services. MTPA may use my Protected Health Information to contact me for any of these purposes by mail, email, and telephone. To opt out of receiving future communications about product access services, I may call the ***JourneyMate Support Program*™** at 1-844-772-4548 or follow the instructions in any communication I receive. I understand that if I opt out from receiving communications, I will no longer be able to participate in or receive assistance from the Out-of-Pocket Assistance Program for RADICAVA®.

Please see Prescribing Information, including Patient Information for RADICAVA®, also available at radicava.com.

Marketing Communications and Market Research Text Message Opt-In

Checking the box above my signature on page 1 serves as confirmation that I authorize MTPA to receive, use, and disclose my Protected Health Information for the following purposes: (i) to send me marketing information related to my condition, my treatment, or related products or services that might be of interest to me; (ii) to contact me occasionally to obtain my feedback for market research purposes about my treatment, my condition, or my experience with RADICAVA®, and/or MTPA; and (iii) to contact me about other products and services offered by MTPA. MTPA may contact me for these purposes by mail, email, and telephone. If I check the YES box on page 1, MTPA may contact me for these purposes using SMS text messages. Marketing communications will include information about how I can opt out of receiving future communications. I understand that my receipt of product access services will not be affected if I choose not to opt in or if I later opt out of marketing communications.

GENERAL INFORMATION

I understand that the pharmacy that ships my medication may be paid to share information with the ***JourneyMate Support Program*™** in order to help provide the offerings requested for me. I also understand that my Protected Health Information will not be used or disclosed by MTPA for any other purpose than described in this Out-of-Pocket Assistance Program Enrollment Form (the "Form") without my authorization unless permitted by law or unless information that specifically identifies me is removed so that the information is "de-identified." I understand that MTPA will make every effort to keep my information private. I understand that information used or disclosed under this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law. For additional information on how MTPA collects, uses, and discloses personal information, I can visit mt-pharma-america.com/privacy-policy. I understand that I am not required to sign this Out-of-Pocket Assistance Program Enrollment Form for RADICAVA®. My decision whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I do not sign the Authorization on page 1 of this Form, or cancel (revoke) my Authorization later, I understand that this means I will not be able to participate in or receive assistance from the ***JourneyMate Support Program*™**. However, I understand I may call the ***JourneyMate Support Program*™** to request assistance at any time. I also understand I may receive a summary of my health insurance benefits, which may be sent to me following a benefit investigation even though I did not sign this Patient Authorization. This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer participating in the ***JourneyMate Support Program*™** services, whichever is sooner. A copy of this Authorization will be as valid as the original. I may cancel this Authorization at any time in writing by mailing a letter to the ***JourneyMate Support Program*™**, 680 Century Point, Lake Mary, FL 32746. I can also cancel my Authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with MTPA. Cancelling this Authorization will not affect the ability of MTPA to use and disclose Protected Health Information that it has received prior to receipt of the cancellation of my Authorization. My Authorization will also end if the ***JourneyMate Support Program*™** is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to MTPA.

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