SEARCHLIGHT SUPPORT®

Out-of-Pocket Assistance Program Enrollment Form

Radicava® (edaravone) IV infusion 30mg/100mL

To enroll in the Searchlight Support® Out-of-Pocket Assistance Program, please complete this form and mail to Searchlight Support®, P.O. Box 2930, Phoenix, AZ 85062 or fax to 1-888-782-6157. For assistance or additional information, call 1-844-SRCHLGT (1-844-772-4548), 8 AM–8 PM ET

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

*FIRST NAME _____ *LAST NAME _____

*ADDRESS _____ *CITY _____ *STATE _____ *ZIP _____

*DATE OF BIRTH (MM/DD/YYYY) _____ *PRIMARY PHONE _____

*INFUSION PROVIDER NAME _____ *PROVIDER PHONE _____

PLEASE CHECK THE BOX BELOW EACH STATEMENT TO CONFIRM THAT YOU ACKNOWLEDGE THESE ELIGIBILITY REQUIREMENTS FOR ENROLLMENT IN THE PROGRAM.

1. Do you currently have commercial insurance with prescription coverage for RADICAVA® (edaravone) 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 (i.e., 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

You must also comply with the Eligibility Requirements & Terms and Conditions on the next page.

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. PATIENT AUTHORIZATION

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Authorization below, to participate in the Searchlight Support® Program ("the Program") and Searchlight Support® Out-of-Pocket Assistance Program and to release my Protected Health Information to Mitsubishi Tanabe Pharma America, Inc. (as defined below), supporting the access program as indicated below in this Patient Authorization. I certify that I have read, understand, and comply with the full Eligibility Requirements & Terms and Conditions on the next page.

My signature below serves as confirmation that I authorize each of my physicians and pharmacists, including any specialty pharmacy 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, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Mitsubishi Tanabe Pharma America, Inc. ("Mitsubishi Tanabe Pharma America"), its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access and assistance programs for Healthcare Providers and patients (Searchlight Support®) (together, "Mitsubishi Tanabe Pharma America") for the purposes described below.

I specifically authorize Mitsubishi Tanabe Pharma America 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 Searchlight Support® programs, including potential enrollment in the Program if I am an eligible, commercially insured patient with insurance coverage for RADICAVA®, or the 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®; (iii) to verify, investigate, assist with, and coordinate my coverage for RADICAVA® with my Insurers; (iv) to coordinate prescription fulfillment, including triaging my information and my prescription to a specialty pharmacy; and (v) to assist with analyses related to the quality, efficacy, and safety of RADICAVA®, and patient access to and treatment compliance with RADICAVA®. I understand that pharmacies that ship my medication may be paid to share this information with Searchlight Support® 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 Mitsubishi Tanabe Pharma America for any other purpose than described in this Form unless permitted by law or unless information that specifically identifies me is removed and therefore "de-identified." I understand that Mitsubishi Tanabe Pharma America 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 Mitsubishi Tanabe Pharma America collects, uses, and discloses personal information, visit mt-pharma-america.com/privacy-policy.

I understand that I am not required to sign the 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 this form, or cancel (revoke) my Authorization later, I understand that this means I will not be able to participate or receive assistance from Searchlight Support®.

This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer participating in Searchlight Support® services, whichever is sooner. I may cancel this Authorization at any time in writing by mailing a letter to Searchlight Support®, P.O. Box 2930, Phoenix, AZ 85062. 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 Mitsubishi Tanabe Pharma America, but this will not affect the ability of Mitsubishi Tanabe Pharma America 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 Searchlight Support® 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 Mitsubishi Tanabe Pharma America.

PATIENT SIGNATURE _____ DATE _____

If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME _____
(Please Print)

AUTHORIZED REPRESENTATIVE _____
(Please Print)

BY _____
(Signature of authorized representative)

RELATIONSHIP TO PATIENT _____ DATE _____

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

Print Form

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

- 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 between 18 and 64 years of age and not eligible for Medicare.
- You must not be enrolled in government health insurance, (i.e., 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 will be automatically re-enrolled on December 31st in subsequent calendar years after the initial enrollment period ends as long as 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 Searchlight Support® 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 service on 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 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, 2019. Mitsubishi Tanabe Pharma America, Inc. has the right to modify, alter, or cancel the Searchlight Support® Out-of-Pocket Assistance Program at any time without prior notification.

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

Mitsubishi Tanabe Pharma America, Inc.
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Mitsubishi Tanabe Pharma America