SEARCHLIGHT SUPPORT ®

Request for Out-of-Pocket Assistance Form

2250 Perimeter Park Drive, Suite 200, Morrisville, NC 27560

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

Medical Benefit Out-of-Pocket Costs

USE THIS FORM if you've already paid your out-of-pocket costs to your infusion provider. Complete and submit the form to receive a check for applicable out-of-pocket costs following validation of all required information.

PLEASE NOTE: If RADICAVA® (edaravone) was obtained/purchased from a specialty pharmacy: See next page and complete the *Request for Out-of-Pocket Assistance Form: Pharmacy Benefit Out-of-Pocket Costs* to request cost support for the applicable out-of-pocket costs for your RADICAVA® medication.

You must be eligible for, and enrolled in, the Searchlight Support® Out-of-Pocket Assistance Program ("the Program") to receive a check for your applicable out-of-pocket costs for your medication and your infusion with RADICAVA®. For full Eligibility Requirements & Terms and Conditions, please refer to the *Searchlight Support® Out-of-Pocket Assistance Program* patient brochure, or visit radicava.com.

How to submit your reimbursement claim for applicable out-of-pocket costs:

1. **Complete the information below and sign the form:**
   - You will need the information found on the front of your program card that was sent to you at the time of enrollment
2. **Include copies of the documents listed below:**
   - Explanation of Benefits (EOB) from your primary health insurance plan (include EOBs from secondary health insurance plan, if any)
   - Proof of payment/receipt from your infusion provider. Please ensure the proof of payment/receipt clearly states:
     - Patient Name
     - Medication (name, J code, or NDC#)
     - Procedure Code (CPT®)
     - Date(s) of Infusion
     - Amount patient paid for RADICAVA® medication and infusion costs

   A submission that does not include these items will not be processed. If submission is approved, a check will be made out to the patient and mailed to the patient's home address.
3. **Send the *Request for Out-of-Pocket Assistance Form* by fax or by mail with EOB and proof of payment/receipt:**

   By Fax: 1-844-695-9284

   By Mail: Searchlight Support®, 2250 Perimeter Park Drive, Suite 200, Morrisville, NC 27560

Complete the information below. (*Required fields)

The information you provide will only be used by Searchlight Support®, our affiliates and our service providers, to provide benefits to you in connection with the Program.

*Name _____ *Date of Birth (MM/DD/YYYY) _____

*Address _____

*City _____ *State _____ *ZIP _____

Email _____ *Phone _____

Information from front of the program card

*Patient ID # _____ *Payer ID # _____

*Group # _____ *Member ID # _____

If you have any questions about the Program, please call 1-844-772-4548.

This form may only be completed by the patient or the patient's legal guardian. This form must be submitted, along with all required documentation, for the patient to receive cost support from the Program for the applicable out-of-pocket amounts the patient has already paid to his or her infusion provider for administering RADICAVA® infusion, consistent with the Eligibility Requirements & Terms and Conditions of the Program, which can be found in the Program patient brochure or online at radicava.com. The patient is responsible for any amounts not covered by the Program.

Patient Signature

I certify that, to the best of my knowledge, the information provided with and on this form is true and correct. By submitting this request, I certify that I have read the Eligibility Requirements & Terms and Conditions of the Program and that I am eligible to receive out-of-pocket assistance from the Program on the request I am submitting for cost support. I certify that I do not have government health insurance, (i.e., Medicare, Medicaid, VA, DoD, or other federal or state assistance programs), and that I have paid my healthcare provider for my share of the cost of administering RADICAVA®, as determined by my commercial health insurance company. I understand that I am responsible for reporting receipt of Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the treatment cost paid for by the Program, as may be required. I authorize the release of any medical information to third parties working on behalf of Mitsubishi Tanabe Pharma America, Inc. necessary to process this request for Program assistance.

Signature ▶ _____ Print Name _____ Date _____

To stop receiving this information or service, you may un-enroll from the Program by contacting Searchlight Support® at 1-844-772-4548.

Mitsubishi Tanabe Pharma America, Inc.
525 Washington Boulevard, Suite 400
Jersey City, NJ 07310

Mitsubishi Tanabe Pharma America

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

Pharmacy Benefit Out-of-Pocket Costs

USE THIS FORM if you've already paid your out-of-pocket costs to a specialty pharmacy. Complete and submit this form to receive a check for applicable out-of-pocket costs following validation of all required information.

PLEASE NOTE: If you received your RADICAVA® (edaravone) medication and your infusion from an infusion provider: See previous page, and complete the *Request for Out-of-Pocket Assistance Form: Medical Benefit Out-of-Pocket Costs* to request cost support for the applicable out-of-pocket costs.

You must be eligible for, and enrolled in, the Searchlight Support® Out-of-Pocket Assistance Program ("the Program") to receive a check for your applicable out-of-pocket costs associated with the purchase/acquisition of RADICAVA®. For full Eligibility Requirements & Terms and Conditions, please refer to the *Searchlight Support® Out-of-Pocket Assistance Program* patient brochure, or visit radicava.com.

How to submit your reimbursement claim for applicable out-of-pocket costs for your RADICAVA® medication:

1. **Complete the information below and sign the form:**
   - You will need the information found on the front of your program card that was sent to you at the time of enrollment
2. **Provide a valid pharmacy receipt/proof of payment which includes:**
   - Patient Name
   - Medication (name, J code, or NDC#)
   - Date(s) of Purchase
   - Amount patient paid for RADICAVA® medication

   A submission that does not include this information will not be processed. If submission is approved, a check will be made out to the patient and mailed to the patient's home address.
3. **Send the *Request for Out-of-Pocket Assistance Form* by fax or by mail with the pharmacy receipt/proof of payment:**

   By Fax: 1-844-695-9284

   By Mail: Searchlight Support®, 2250 Perimeter Park Drive, Suite 200, Morrisville, NC 27560

Complete the information below. (*Required fields)

The information you provide will only be used by Searchlight Support®, our affiliates and our service providers, to provide benefits to you in connection with the Program.

*Name _____ *Date of Birth (MM/DD/YYYY) _____

*Address _____

*City _____ *State _____ *ZIP _____

Email _____ *Phone _____

Information from front of the program card

*Patient ID # _____ *Payer ID # _____

*Group # _____ *Member ID # _____

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Patient Signature

I certify that, to the best of my knowledge, the information provided with and on this form is true and correct. By submitting this request, I certify that I have read the Eligibility Requirements & Terms and Conditions of the Program and that I am eligible to receive out-of-pocket assistance from the Program on the request I am submitting for cost support. I certify that I do not have government health insurance, (i.e., Medicare, Medicaid, VA, DoD, or other federal or state assistance programs), and that I have paid my healthcare provider for my share of the cost of administering RADICAVA®, as determined by my commercial health insurance company. I understand that I am responsible for reporting receipt of Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the treatment cost paid for by the Program, as may be required. I authorize the release of any medical information to third parties working on behalf of Mitsubishi Tanabe Pharma America, Inc. necessary to process this request for Program assistance.

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