Benefit Investigation and Enrollment Form

Getting Started on RADICAVA ORS® (edaravone) Treatment

Radicava ORS® (edaravone) Oral Suspension 105mg/5mL

Patients, their care partners, and HCP offices can work together to READ, FILL OUT, and SIGN the pages in this form.

Once that's complete, HCP offices SUBMIT PAGES 1-5 to the *JourneyMate Support Program*™ by:

Fax to 1-888-782-6157 OR Mail to 680 Century Point, Lake Mary, FL 32746

For assistance with this form, call 1-844-772-4548, Monday-Friday, 8:00 AM - 8:00 PM ET.

Or you can complete, sign, and submit the form online at www.RadicavaOnlineEnrollmentForm.com

PATIENTS to read, fill out, and sign (a legal representative can do this if the patient is not able)

Patient Authorization—Pages 1 & 2

- **PATIENT** authorizes the steps needed to start RADICAVA ORS®. **A SIGNATURE IS REQUIRED** on page 2.
- Signing page 2 will enroll patients in the ***JourneyMate Support Program***™.

Benefit Investigation and Enrollment Form—Page 3

- **PATIENT** provides required personal and insurance information.

HCP OFFICES to read, fill out, and sign

Benefit Investigation and Enrollment Form (cont'd)—Pages 4 & 5

- **HCP OFFICE** provides the required office and prescription information. **A SIGNATURE IS REQUIRED** on page 5.

Information for HCPs to Review—Last Page

- **HCP OFFICE** reviews important disclaimer information. **DO NOT SUBMIT THIS PAGE.**

Patients and care partners can access treatment support by calling 1-844-772-4548, Monday through Friday, between 8:00 AM and 8:00 PM Eastern Time

Learn more at Radicava.com/JMSupportProgram

JourneyMate SUPPORT PROGRAM™

Dedicated Team. Patient-Focused Approach.

Please see the accompanying full Prescribing Information and Patient Information, also available at www.RadicavaORS.com.

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Patient Authorization

PATIENT AUTHORIZATION

I authorize each of my physicians and pharmacists, including any specialty pharmacy that receives my prescription for RADICAVA ORS® (edaravone) and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to use and disclose my personal information, including, but not limited to, contact information, demographic information, financial information, medical records and history, information related to my medical condition and treatment, information related to my health insurance and benefits (together, "Personal Information") to Tanabe Pharma America, Inc., its affiliated companies, agents and representatives (together, "Tanabe Pharma America" or "TPA"), including providers of alternate sources of funding for prescription drug costs, and vendors providing relevant patient education programs and other service providers supporting access and assistance programs for Healthcare Providers and patients for the purposes described below (***JourneyMate Support Program***™). I specifically authorize TPA to receive, use, and disclose my Protected Health Information for the following purposes:

- to enroll me in, and contact me and/or the person legally authorized to sign on my behalf about, the ***JourneyMate Support Program***™, including potential enrollment in the Out-of-Pocket Assistance Program for RADICAVA ORS® if I am an eligible, commercially insured patient with insurance coverage for RADICAVA ORS®, or the Patient Assistance Program, if I have no insurance and meet eligibility requirements;
- to provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to RADICAVA ORS® and to contact me about enrolling in a relevant patient education program;
- to provide access support education, including contacting my Healthcare Providers regarding my coverage for RADICAVA ORS®;
- to assist with analyses related to the quality, efficacy, and safety of RADICAVA ORS® and patient access to and treatment compliance with RADICAVA ORS®;
- to enhance and improve the product access services; and

TPA may use my Personal 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 ORS®.

GENERAL INFORMATION

I understand that pharmacies that ship my medication may be paid to share my Personal Information with the ***JourneyMate Support Program***™ for the purposes listed in this Patient Authorization. I also understand that my Personal Information will not be used or disclosed by TPA for any other purpose than described in this Benefit Investigation and Enrollment Form (the "Form") without my authorization unless permitted or required by law or unless information that identifies me is removed so that the information is "de-identified." 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 TPA collects, uses, and discloses Personal Information, I can visit us.tanabe-pharma.com/privacy-policy.

I understand that I am not required to sign this Patient Authorization for RADICAVA ORS®. I further understand that my decision on whether to sign will have no effect on any treatment, payment, or eligibility with my Healthcare Provider or Insurer. If I do not sign the Authorization on page 2 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***™. This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer participating in ***JourneyMate Support Program***™ services, whichever is sooner, unless a shorter period is required under the laws in the state I reside. 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 ***JourneyMate Support Program***™, 680 Century Point, Lake Mary, FL 32746. Cancelling this Authorization will not affect the ability of TPA to use and disclose Personal 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 receive a copy of this Patient Authorization and to see or copy the Personal Information my Healthcare Providers or Insurers have given to TPA.

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Patient Authorization (cont'd)

I HAVE READ THIS AUTHORIZATION AND AGREE TO ITS TERMS

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Authorization included on page 1 and agree to the release and use of my Personal Information for the purposes described above.

AUTHORIZATION TO RECEIVE MARKETING COMMUNICATIONS

☐ By checking the box, I authorize Tanabe Pharma America, Inc. ("TPA") and its collaborators, affiliates, and agents (third parties working with or on behalf of TPA) (together the "TPA Parties") to receive, use, and disclose my Protected Health Information to (a) send me communications with optional information and/or materials related to disease state, products, promotions, services, research studies, and more, and (b) ask my opinion about such information and topics, including performing marketing research and disease-related surveys.

If you have provided a Mobile Phone number:

AUTHORIZATION TO RECEIVE EDUCATIONAL CALLS OR TEXT MESSAGES

☐ By checking this box and signing below, I am agreeing to receive recurring autodialed and/or pre-recorded marketing calls and recurring automated text messages to the number I entered on Page 3 from and on behalf of the ***JourneyMate Support Program***™ about ALS, treatment options, status, reminders and more. Consent is not required nor is it a condition for purchase. Message and data rates may apply. Text STOP to 85427 to stop (confirmation text may be sent). Text HELP to 85427 for help. I agree to the Terms of Use (us.tanabe-pharma.com/terms-of-use) and Privacy Policy (us.tanabe-pharma.com/privacy-policy).

AUTHORIZATION TO CONTACT YOU ABOUT SHARING YOUR STORY

☐ I may want to share my experience about my disease and RADICAVA ORS®. Please contact me after I start treatment.

I may consider creating: ☐ Video Content ☐ Written Content ☐ Both Video and Written Content

Patient Signature _____ Date _____

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

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

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Benefit Investigation and Enrollment Form

1. PATIENT INFORMATION (REQUIRED)

First Name _____ MI _____ Last Name _____ Suffix _____

Address _____ City _____ State _____ ZIP _____

Email Address _____ DOB (MM/DD/YYYY) _____ Gender ☐ M ☐ F ☐ Prefer not to say

Phone Number _____ This Number Is: ☐ Mobile ☐ Home ☐ Okay to Leave Voicemail

Language Preference (if Not English) _____ Are You Nonverbal? ☐ Yes ☐ No (If Yes, Select "Additional Contact" as Preferred Contact Person Below.)

Additional Contact Name _____ Relationship to Patient _____

Phone Number _____ This Number Is: ☐ Mobile ☐ Home ☐ Okay to Leave Voicemail

Preferred Contact ☐ Me ☐ Additional Contact Preferred Method ☐ Phone ☐ Text ☐ Email

2. PATIENT INSURANCE INFORMATION (REQUIRED. Include letters before and after policy and group numbers when applicable.)

- **All relevant sections of the form should be filled out**
- **Include copies of the front and back of all medical and pharmacy insurance cards**
- **Do you have Veterans Affairs (VA) health coverage?** ☐ Yes ☐ No

☐ **I do not have insurance. Please send me an application for the Patient Assistance Program.**

Pharmacy Insurance _____ Cardholder Name _____

DOB (MM/DD/YYYY) _____ Relationship to Cardholder _____

Pharmacy Phone _____ Member ID # _____

Group ID # _____ PCN # _____ Rx Bin # _____

Medicare Part D ☐ Yes ☐ No Supplemental or Secondary Insurance ☐ Yes ☐ No ☐ Are you a Dependent of the Insured (Child <18 yrs; Student >18 yrs)? Check if Yes

Cardholder Name _____ DOB (MM/DD/YYYY) _____

Relationship to Cardholder _____ Employer _____

Ins Co Phone _____ Policy # _____ Group # _____

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Benefit Investigation and Enrollment Form (cont'd)

3. PRESCRIBER OFFICE INFORMATION (REQUIRED)

Prescriber Name (First, Last) _____

Practice Name _____

Specialty _____

Address _____

City _____ State _____ ZIP _____

Email _____

Phone _____ Fax _____

Medicaid/Medicare Provider # (PTAN) _____

Tax ID # _____

State License # (Optional, but Required in Puerto Rico) _____

NPI # _____

VA Prescriber ☐ Yes ☐ No

Preferred Office Contact Name (If Different Than Above) _____

Email _____

Phone _____ Fax _____

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Benefit Investigation and Enrollment Form (cont'd)

DO NOT FILL OUT AND SUBMIT THIS PAGE FOR PATIENTS WHO INDICATE THEY HAVE VETERANS AFFAIRS (VA) HEALTH COVERAGE on page 3, and who live in a state that requires submission of electronic prescriptions. Patients who have VA health coverage must follow VA internal pharmacy rules based on their insurance.

4. PRESCRIPTION INFORMATION (REQUIRED) ICD-10: G12.21 Amyotrophic lateral sclerosis

SPECIAL NOTE: If attaching a prescription, physician must comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in follow-up and delayed processing.

Time Since Diagnosis ☐ Newly Diagnosed ☐ 1 Year or More ☐ Unknown

Treatment type(s) used for condition besides RADICAVA ORS®
☐ Oral Therapy ☐ Infusion/Injection Therapy ☐ Enrolled in Clinical Trial ☐ Not Applicable

☐ **STARTER DOSE:** Administer 105 mg (5 mL) orally or via feeding tube once daily for 14 consecutive days, followed by a 14-day drug-free period; quantity: 70 mL. **No refills (0)**

☐ **SUBSEQUENT DOSE:** Administer 105 mg (5 mL) orally or via feeding tube once daily for 10 days out of 14 days, followed by 14-day drug-free periods; quantity: 50 mL. **Refills (Quantity)** ☐ 11 ☐ Other _____

By signing this form, I certify and acknowledge that I have read, understand, and agree to the Healthcare Provider Disclaimer and the Healthcare Provider Attestation for the Patient Assistance Program on the last page of this form. I am also indicating a prescribing decision has been made. In addition, I am certifying treatment with RADICAVA ORS® indicated above is medically necessary for this patient, and the patient has provided me with written authorization to release the patient's medical and/or other Personal Information relating to this therapy to Tanabe Pharma America, Inc., its affiliated companies, agents, and representatives (including, where applicable, the vendor providing a relevant patient education program) for their use and disclosure as specified in the Patient Authorization on pages 1 & 2 of this form, including (1) to contact this patient to help obtain a signed Patient Authorization and/or (2) to refer the patient to or contact the patient for purposes of enrollment in a patient education program. I certify that, to the best of my knowledge, the patient and physician information in this form is complete and accurate. If I am attaching a prescription, I certify that I have prescribed the product based on my professional judgment of medical necessity. I authorize UBC to conduct an investigation of this patient's pharmacy and medical health insurance benefits on my behalf in connection with this enrollment form.

PHYSICIAN SIGNATURE REQUIRED TO PROCESS PATIENT ENROLLMENT: I have reviewed the current RADICAVA ORS® Prescribing Information and I will be supervising the patient's treatment. If I have attached a prescription, I authorize the *JourneyMate Support Program*™ to act on my behalf to transmit the prescription to a contracted specialty pharmacy.

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Physician Signature _____ **Date (Required)** _____

OR

May Substitute / Product Selection Permitted / Substitution Permissible

Physician Signature _____ **Date (Required)** _____

CA, MA, NC, & PR: Interchange is mandated unless Prescriber writes the words **"No Substitution"** _____
ATTN: New York and Iowa providers, please submit electronic prescription

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Information for HCPs to Review

HEALTHCARE PROVIDER DISCLAIMER

By providing your information and information about your patient on pages 2-5 of this Benefit Investigation and Enrollment Form, you are requesting to participate in the ***JourneyMate Support Program***™ and its programs for RADICAVA ORS® (edaravone). The information you provide will only be used by Tanabe Pharma America, Inc. ("Tanabe Pharma America"), our affiliates, and our service providers involved in managing and delivering these services and programs. You may withdraw your request for these services at any time by calling 1-844-772-4548. You agree to be contacted by Tanabe Pharma America at the ***JourneyMate Support Program***™ by mail, fax, email, or telephone for the purposes of managing and delivering these services and programs. Our Privacy Policy, available at us.tanabe-pharma.com/privacy-policy, governs the use of the information you provide. By providing the information on this form and submitting this form, you indicate that you have read, understand, and agree to these terms and agree to receive program-related communications from the ***JourneyMate Support Program***™ and its service providers. Please contact the ***JourneyMate Support Program***™ at 1-844-772-4548 if you wish to change your communication preferences.

Patient insurance benefit investigation is provided as a service by service providers under contract for Tanabe Pharma America. Our service providers assist in determining whether treatment can be covered by the payer based on the payer's health plan guidelines and the patient information you provided as authorized by the patient on the Benefit Investigation and Enrollment Form, following your determination of medical necessity. Patient out-of-pocket cost support through the Out-of-Pocket Assistance Program is provided to eligible patients as a service by service providers under contract for Tanabe Pharma America.

Verification of insurance coverage is ultimately the responsibility of the Healthcare Provider. Since reimbursement by payers is subject to many factors, Tanabe Pharma America and our service providers do not represent or guarantee that payer reimbursement or any other payment or reimbursement of any kind will be made. Tanabe Pharma America and our service providers do not reimburse for claims denied by payers. Information provided as a result of the benefit investigation is provided for general reference and informational purposes only. Our service providers make every effort to be accurate in the information provided; however, no representations or warranties are expressed or implied by our service providers and Tanabe Pharma America regarding the accuracy or reliability of the information. Our service providers or Tanabe Pharma America, or its agents or employees shall not be liable legally, financially, or otherwise, for damages of any kind as a result of or related to these services. Our service providers and other users of this information resulting from benefit investigation services accept full responsibility for use of the service.

Tanabe Pharma America does not assume responsibility for, nor does it guarantee the availability, scope, or quality of the services offered including reimbursement support, prescription fulfillment coordination, and other services under the ***JourneyMate Support Program***™. Healthcare Providers, not Tanabe Pharma America, are responsible for the services they provide. The ***JourneyMate Support Program***™ services have no value apart from the product.

HEALTHCARE PROVIDER ATTESTATION FOR THE PATIENT ASSISTANCE PROGRAM

If the patient identified on page 3 of this form is determined to be eligible to participate in the Patient Assistance Program (the "Program"), I confirm that to the best of my knowledge, the patient does not have health insurance of any type, for example, but not limited to, an HMO, Private Insurance, State Pharmacy Program, Medicare, Medicaid, or Veterans Assistance. By signing page 5 of this form, I attest that I do not and will not bill, charge, seek credit for or otherwise submit any claim for reimbursement to any third-party payer or the patient for the product the patient receives at no charge through the Program. I understand that the Program does not include the cost of any associated services such as administration of product or Healthcare Provider visits. I also understand it is my responsibility to promptly inform the Program of any information that changes from what is being submitted on page 5 of this Benefit Investigation and Enrollment Form for RADICAVA ORS®.

Please see the accompanying full Prescribing Information and Patient Information, also available at www.RadicavaORS.com.

Tanabe Pharma America

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