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

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 INFORMATION (REQUIRED)

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

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOBILE PHONE _____ HOME PHONE _____

PREFERRED NUMBER TO CALL ☐ Mobile Phone ☐ Home Phone ☐ Okay to Leave Voicemail LANGUAGE PREFERENCE (if not English) _____

EMAIL _____

PLEASE ANSWER QUESTIONS BELOW FOR ELIGIBILITY DETERMINATION.

1. Do you currently have private, commercial insurance with prescription coverage for RADICAVA ORS® (edaravone) medication, and your insurance does not cover the entire cost of RADICAVA ORS®?

☐ 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: Medicare Parts C or D, Medicaid, VA, DoD, or any other federal or state health insurance program?

☐ Yes ☐ No

3. Do you confirm that you will not seek reimbursement or compensation from any third-party account or fund?

☐ Yes ☐ No

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

2. INSURANCE INFORMATION (REQUIRED)

PHARMACY INSURANCE _____ CARDHOLDER NAME _____ **DOB** (MM/DD/YYYY) _____

RELATIONSHIP TO CARDHOLDER _____ PHARMACY HELP DESK PHONE _____

MEMBER ID # _____ GROUP ID # _____ PCN # _____ Rx BIN # _____

MEDICARE PART D ☐ Yes ☐ No SUPPLEMENTAL INSURANCE ☐ Yes ☐ No ☐ Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.

MEDICAL INSURANCE _____ GROUP/PLAN NAME _____

CARDHOLDER NAME _____ **DOB** (MM/DD/YYYY) _____ RELATIONSHIP TO CARDHOLDER _____

POLICY # _____ GROUP # _____ INS. CO. PHONE _____ STATE _____

SECONDARY INSURANCE _____ GROUP/PLAN NAME _____

CARDHOLDER NAME _____ **DOB** (MM/DD/YYYY) _____ RELATIONSHIP TO CARDHOLDER _____

POLICY # _____ GROUP # _____ INS. CO. PHONE _____ STATE _____

3. 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 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

Eligibility Requirements & Terms and Conditions for the Out-of-Pocket Assistance Program for RADICAVA ORS® (edaravone)

- Patients who meet all eligibility criteria and are enrolled in the Out-of-Pocket Assistance Program may pay as little as $0 per RADICAVA ORS® prescription dispense, subject to a maximum annual benefit limit per calendar year
- You must currently have private, commercial health insurance with prescription coverage for RADICAVA ORS®, and your insurance does not cover the entire cost of the medication. Offer is not valid for cash-paying patients
- You are not eligible for RADICAVA ORS® assistance if you are enrolled in or become enrolled in Medicare Part C (Medicare Advantage), Medicare Part D (prescription drug benefit), Medicaid, Department of Veterans Affairs (VA), Department of Defense (DoD), or any other federal or state health insurance program. Patients enrolled in commercial prescription drug insurance and Medicare Part A (hospital benefit) and/or Medicare Part B (medical benefit) are eligible for assistance so long as they meet all other eligibility criteria
- You may not seek reimbursement or compensation, in whole or in part, from any government health insurance
- By enrolling in the Out-of-Pocket Assistance Program, you agree that the Program is intended solely for the benefit of you as the patient. Some health plans have established programs referred to as "accumulator adjustment" or "co-pay maximizer" programs. An accumulator adjustment program is one in which payments made by you that are subsidized by manufacturer assistance do not count toward your deductibles and other out-of-pocket cost sharing limitations. Co-pay maximizers are programs in which the amount of your out-of-pocket costs is increased to reflect the availability of support offered by a manufacturer assistance program. The Out-of-Pocket Assistance Program is not intended for patients in accumulator or maximizer programs. Tanabe Pharma America, Inc. reserves the right to modify or discontinue assistance at any time for patients found to be subject to an accumulator adjustment or co-pay maximizer program. You also agree that you are personally responsible for paying any amount of co-pay required after the Out-of-Pocket Assistance Program support is applied.
- You must be at least 18 years of age
- 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
- This offer may not be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription
- This Out-of-Pocket Assistance Program is not valid outside the US or in states where prohibited by law, taxed, or otherwise restricted
- You are being treated as an outpatient by a licensed healthcare provider in the US and have been prescribed RADICAVA ORS® by a licensed healthcare provider
- You must re-enroll annually to remain in the Out-of-Pocket Assistance Program. To re-enroll, reverification of your insurance benefit is required to confirm that you continue to meet the eligibility requirements for participation in the Out-of-Pocket Assistance 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
- Claims must be submitted in a timely manner
- 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, 2026. 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 full Prescribing Information, including Patient Information, available at radicavaors.com.

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 and the *JourneyMate Support Program*™ and to release my Protected Health Information to 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 page 1 serves as confirmation that 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 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 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***™).

- **Product Access Services Enrollment**
  I specifically authorize TPA 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***™, 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; (ii) 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; (iii) to provide access support education, including contacting my Healthcare Providers regarding my coverage for RADICAVA ORS®; (iv) to assist with analyses related to the quality, efficacy, and safety of RADICAVA ORS® and patient access to and treatment compliance with RADICAVA ORS®; and (v) to enhance and improve the product access services. TPA 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 ORS®.

Please see full Prescribing Information, including Patient Information, available at radicavaors.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 TPA 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 ORS® and/or TPA; and (iii) to contact me about other products and services offered by TPA. TPA may contact me for these purposes by mail, email, and telephone. If I check the box on page 1, TPA 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 pharmacies that ship my medication may be paid to share this 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 TPA 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 TPA 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 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 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 ***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***™ Insurance & Access Specialist, 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 TPA. Cancelling this authorization will not affect the ability of TPA 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 TPA.

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