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

Benefit Investigation and Enrollment Form

Fax this completed form to 1-888-782-6157 or mail to ***JourneyMate Support Program***™, 680 Century Point, Lake Mary, FL 32746. For assistance or additional information, call 1-844-772-4548, Monday-Friday, 8:00 AM-8:00 PM ET.

IMPORTANT: PATIENT AUTHORIZATION INFORMATION

Patient Authorization **IS REQUIRED** to enroll your patient in ***JourneyMate Support Program***™ services, using the following options:

1. **If the patient or Legal Representative is available in your office, they may read PAGES 4 and 5 and sign the Patient Authorization on PAGE 3.**
2. If the patient is unavailable, the ***JourneyMate Support Program***™ may contact the patient to obtain the patient's authorization via online, email, mail, or fax, using the Patient Authorization Form. Physician signature is required for the program to contact the patient.

PATIENT NAME _____ **DOB** (MM/DD/YYYY) _____

1. PRESCRIBER OFFICE INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____ PRACTICE NAME _____ SPECIALTY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____ PTAN # _____

STATE LICENSE # (Optional) _____ UPIN/NPI # _____ VA PRESCRIBER ☐ YES ☐ NO

PREFERRED OFFICE CONTACT NAME (IF DIFFERENT THAN ABOVE) _____

EMAIL _____ PHONE _____ FAX _____

2. PATIENT INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable.)

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD FOR EACH TYPE OF INSURANCE.

Patients with no insurance will be contacted by the *JourneyMate Support Program*™ for consideration in the Patient Assistance Program.

VETERANS AFFAIRS (VA) COVERAGE/BENEFITS ☐ Yes ☐ No VETERANS WHO ARE NOT TRICARE BENEFICIARIES & DO NOT HAVE SECONDARY INSURANCE, PROCEED TO SECTION 3.

Veterans and patients enrolled in government health insurance (ie, Medicare, Medicaid, VA, DoD, or other federal or state assistance programs) do not qualify for the Out-of-Pocket Assistance Program.

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 _____

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

SECONDARY INSURANCE _____ GROUP/PLAN NAME _____

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

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

3. 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.

CHECK TO INDICATE PRESCRIBING PREFERENCE FOR RADICAVA ORS®

RADICAVA ORS® (edaravone) 105 mg (5 mL) Oral Suspension

For patients new to RADICAVA ORS®, check both Starter Dose and Subsequent Dose, and Refills quantity. Starter Dose is recommended as the initial treatment cycle. See accompanying Prescribing Information.

☐ **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 page 2 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 page 4 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)**

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**

Healthcare Provider Disclaimer

By providing your information and information about your patient on pages 1 and 3 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 1 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 1 of this Benefit Investigation and Enrollment Form for RADICAVA ORS®.

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

Healthcare Provider Instructions: Use this page to obtain signed Patient Authorization in the office.

1. **Instruct patient to read pages 4 and 5 and sign as appropriate.**
2. **Give patient a copy of this form in its entirety once completed.**
3. **Submit this page along with the completed Benefit Investigation and Enrollment Form. See fax instructions on page 1.**

PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last, Suffix) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ DOB (MM/DD/YYYY) _____ GENDER ☐ M ☐ F

MOBILE PHONE _____ HOME PHONE _____

PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Mobile Phone ☐ Okay to Leave Voicemail

LANGUAGE PREFERENCE (if not English) _____

ADDITIONAL CONTACT NAME _____ RELATIONSHIP TO PATIENT _____

MOBILE PHONE _____ HOME PHONE _____

PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Mobile Phone ☐ Okay to Leave Voicemail

☐ 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. Read Text Message Terms and Conditions (radicava.com/mobile) and Privacy Policy (us.tanabe-pharma.com/privacy-policy).

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 4, to participate in the ***JourneyMate Support 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 4.

☐ 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 4.

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

PATIENT AUTHORIZATION

My signature on page 3 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®.

- **Marketing Communications and Market Research Text Message Opt-In**

  Checking the box above my signature on page 3 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 3, 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 Benefit Investigation and 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 3 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, 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. 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.

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

PATIENT ASSISTANCE PROGRAM ACKNOWLEDGMENT

My signature below serves as confirmation of the following:

- If I am eligible to participate in the Patient Assistance Program (the "PAP") for RADICAVA ORS® (edaravone), I agree to notify the ***JourneyMate Support Program***™ if my insurance situation changes, and I understand that upon obtaining health insurance, I will no longer be eligible to participate in the PAP and that the medication provided to me under the PAP will no longer be dispensed to me.
- My eligibility to receive assistance in the PAP will be reviewed every 12 months and may change if I no longer meet the current program eligibility requirements. For program eligibility requirements, terms, and conditions, I can refer to the PAP brochure.
- Additionally, I acknowledge and agree that I will not seek credit for or otherwise submit any claim for reimbursement to any third-party payer for the RADICAVA ORS® medication provided at no charge by the PAP and that I will not seek to have free medication or any associated costs counted toward my Medicare Part D true out-of-pocket (TrOOP) costs for prescription drugs.
- I understand and agree that the PAP covers only the cost of RADICAVA ORS® and not the cost of any Healthcare Provider visits, which are my sole responsibility.
- I understand that the ***JourneyMate Support Program***™ has the right to verify my eligibility, including the right to audit any information provided on page 3 and to contact me to confirm receipt of medications.
- I authorize Tanabe Pharma America ("TPA") under the Fair Credit Reporting Act to use my demographic information to access reports on my individual credit history from consumer reporting agencies. I understand that, upon request, TPA will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize TPA to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, to estimate my income in conjunction with the PAP eligibility determination process, if applicable.
- I understand that the PAP may be revised, changed, or terminated at any time without notice.

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Assistance Program Acknowledgment above to participate in the Patient Assistance Program.

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 the accompanying full Prescribing Information, including Patient Information for RADICAVA ORS®, also available at radicava.com.

Tanabe Pharma America, Inc.
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Tanabe Pharma America