LEQEMBI® (lecanemab-irmb) 100 mg/mL
INJECTION FOR INTRAVENOUS USE

Eisai Patient Support

Phone: 1-833-453-7362 • Fax: 1-833-770-7017
Monday–Friday: 8 AM-8 PM ET

Eisai Patient Support Enrollment Form

Patient's name _____ DOB (MM/DD/YYYY) _____

Patient and medical insurance information — ALL FIELDS REQUIRED

Patient's name (First, Middle, Last)	DOB (MM/DD/YYYY)	Sex ☐ Male ☐ Female
Address	City / State / Zip	
Home phone	Cell phone ☐ OK to leave a message	
Email address	Preferred language ☐ English ☐ Spanish ☐ Other _____	
Preferred contact method ☐ Home phone ☐ Cell phone ☐ Email	Best time to call ☐ Morning ☐ Afternoon ☐ Evening	
Care partner's name	Relationship	Phone number
Physician name (First, Last)	Physician phone	

Primary insurance information (Please complete if applicable)

☐ No insurance ☐ Medicare ☐ Medicaid ☐ Commercial/private insurance plan ☐ Other

Primary insurance company	Phone number
Policy/Member ID	Group/Account number
Policy holder name (If the patient is not the employee/policy holder)	DOB (MM/DD/YYYY if the patient is not the employee/policy holder)

Secondary insurance information (Please complete if applicable)

☐ Medicare ☐ Medicaid ☐ Commercial/Private insurance plan ☐ Other

Secondary insurance company	Phone number
Policy/Member ID	Group/Account number
Policy holder name (If the patient is not the employee/policy holder)*	DOB (MM/DD/YYYY if the patient is not the employee/policy holder)

*If patient has additional health insurance coverage beyond the fields provided, please provide front and back copies of the patient's additional insurance cards with the submission of this form.

Eisai Patient Support Enrollment Form

Patient's name _____ DOB (MM/DD/YYYY) _____

Patient use (cont'd)

Patient authorization for use and disclosure of health information

By signing this Authorization, I authorize each of my physicians, infusion sites, pharmacists, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my personal health information, including 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 Eisai Inc., its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Eisai") supporting the Eisai Patient Support Program for LEQEMBI (collectively, the "Program") so that the Program may take the following steps to provide me with support services (the "Services"):

I. Process my enrollment (or re-enrollment, as applicable) and determine my eligibility for the Program's financial assistance, copay assistance, and temporary supply Services, including benefit verifications and prior authorizations support,
II. Provide me with the Program's online support, financial assistance Services, and copay assistance Services,
III. Verify, investigate, coordinate, and communicate with my Healthcare Providers and Insurers about my insurance benefits and coverage, and my medical care and prescribed medication,
IV. Facilitate dispensing of my prescription by a non-commercial pharmacy,
V. Provide me with disease management and other educational materials, information, and Services related to my treatment experience with my prescribed medication and my condition,
VI. Communicate with me about my medication and treatment, including adherence materials, reminders, health and lifestyle tips, and product and other related information,
VII. Conduct surveys, data analytics, market research, quality assurance and improvement purposes, and other internal business activities related to the Program and Eisai products and programs,

Eisai Patient Support Enrollment Form

Patient's name _____ DOB (MM/DD/YYYY) _____

Patient use (cont'd)

VIII. Contact me via postal mail, email, phone or text message at the number(s) I provide about the Program or any issues related to the Program

I further authorize the use and disclosure of my Protected Health Information to my Healthcare Providers, Insurers, government agencies, other assistance programs, caregivers, or legally authorized representatives that I designate for the foregoing purposes. By designating a specific caregiver or authorized representative, I am authorizing that individual to provide information regarding my insurance plans, financial status, and other information necessary to facilitate my participation in the Program.

I understand that:

- Once my Protected Health Information is shared, it may no longer be protected by federal privacy laws and it could be disclosed to others. However, Eisai intends to use and share my Protected Health Information only as described in this Authorization or as otherwise permitted by law
- I may refuse to sign this Authorization, and choosing not to sign it will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program or the Services provided by the Program
- My signed Authorization will remain in effect for 5 years from the date of my signature below, or such shorter period that may be prescribed by state law
- I may revoke this Authorization at any time by mailing a request to 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067, faxing a request to 1-833-770-7017, or calling 1-833-453-7362. I also understand that revoking this Authorization will make it invalid with respect to uses and disclosures of my Protected Health Information after the date my revocation letter is received, but that it will not invalidate uses and disclosures made in reliance upon the Authorization prior to that date
- I am entitled to receive a copy of this Authorization

Eisai Patient Support Enrollment Form

Patient's name _____ DOB (MM/DD/YYYY) _____

Patient use (cont'd)

Patient authorization for use and disclosure of health information

Signature required for Eisai Patient Support enrollment

Name of patient _____ Patient signature _____ Date _____

Name of authorized representative _____ Authorized representative signature _____ Date _____

Relation to patient _____

Permission for LEQEMBI marketing communications outside Eisai Patient Support Program (OPTIONAL)

☐ YES, I'd like to receive reminders, education, lifestyle tips, and other resources relating to LEQEMBI and Alzheimer's disease from Eisai separately from the Eisai Patient Support Program (email required)

LEQEMBI Temporary Supply Program terms and conditions

The Temporary Supply Program provides a temporary free supply of up to 75 days of LEQEMBI for eligible, commercially insured patients awaiting a final coverage determination from their insurance provider for 5 or more business days and the patient's provider has submitted a first-level appeal of the prior authorization denial. Patient must have a valid prescription for LEQEMBI for an FDA-approved indication and meet certain financial need criteria. Not available for uninsured patients or patients enrolled in state and federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DoD or TRICARE. Eisai reserves the right to rescind, revoke, or amend this Program at any time without notice. To review complete terms and conditions, visit EisaiPatientSupport.com/LEQEMBI.

LEQEMBI Patient Assistance Program terms and conditions

The Patient Assistance Program for LEQEMBI provides free drug for eligible patients who meet financial need and insurance coverage criteria. Patient must have a valid prescription for LEQEMBI for an FDA-approved indication. Eisai reserves the right to rescind, revoke, or amend this Program at any time without notice. To review complete terms and conditions, visit EisaiPatientSupport.com/LEQEMBI.

LEQEMBI Patient Assistance and Temporary Supply Programs attestation

Signature required for Temporary Supply Program and Patient Assistance Program enrollment

I certify that all of the information provided in this application is complete and accurate. I understand that completing this form does not ensure that I will qualify for the Patient Assistance Program ("PAP") or the Temporary Supply Program ("TSP") (together, the "Programs"). I understand that Program enrollment will terminate if LEQEMBI is no longer prescribed to me. I understand that during the Program enrollment period, I must receive all LEQEMBI doses through the Program only. I agree to notify and shall be responsible for notifying the Eisai Patient Support Program ("EPS") for LEQEMBI at 1-833-453-7362 immediately if anything changes with my LEQEMBI prescription, income, or my insurance coverage. I understand and agree that I will not seek reimbursement or credit from, or submit a claim for LEQEMBI provided through the Programs to any insurer, health plan, or government program (such as Medicare or Medicaid). I also understand and agree that I may not seek to have any part of the value of the LEQEMBI provided to me free of charge from the Programs count towards any applicable out-of-pocket spending calculations for drugs (eg, deductible, out-of-pocket cap, or True Out of Pocket ("TrOOP") associated with my insurance). I understand that the provision of LEQEMBI as part of the Programs is not contingent on any future purchase of LEQEMBI.

Eisai Patient Support Enrollment Form

Patient's name _____ DOB (MM/DD/YYYY) _____

Patient use (cont'd)

I understand that Eisai Inc. reserves the right at any time and without notice to me to modify and/or discontinue the PAP and/or TSP (in whole or in part), including modification of eligibility criteria and immediate termination of assistance provided by the PAP and TSP. I understand that I may decline to sign this form and decline to be evaluated for the PAP and TSP.

I understand that verification of my income may be required in order for EPS to assess my Program eligibility. By signing below, I authorize Eisai Inc. and its service providers administering the PAP and TSP to obtain from Experian Health the financial information from my credit profile or other financial information that Eisai needs to determine my financial eligibility in Eisai's PAP. I also agree to provide Eisai with additional financial documentation in a timely manner, if so requested.

Name of patient _____ Patient signature _____ Date _____

Name of authorized representative _____ Authorized representative signature _____ Date _____

Relation to patient _____

LEQEMBI Copay Assistance Program terms and conditions

Patient must be prescribed LEQEMBI for an FDA-approved indication. Patient must have private, commercial health insurance that provides coverage for LEQEMBI. The offer is not valid for patients enrolled in state and federal healthcare programs, including Medicare, Medicaid, Medigap, VA, DOD, or TRICARE, that cover outpatient care, including for physician-administered or prescription drugs, or otherwise cover LEQEMBI. The offer is not valid for uninsured or self-paying patients, or for LEQEMBI treatments reimbursed in full by any third-party payer. Patient must be 18 years or older. Patient must be a resident of, and product must be administered in, the United States or Puerto Rico.

The benefit available under the LEQEMBI Copay Assistance Program is limited to patient's out of pocket cost for LEQEMBI, as indicated in documentation provided by the patient's health insurance provider, including a CMS-1500 or UB-04 form and an insurance explanation of benefits (EOB) with itemized charges that include the billing code for LEQEMBI. Eligible patients who participate in the Program may pay as little as $0 out-of-pocket per date of treatment. Eisai Inc. will pay up to $10,000 per calendar year toward an eligible patient's out-of-pocket costs for LEQEMBI, including deductibles, copays, and coinsurances. Depending on the patient's insurance plan, patient could have additional financial liability for any amount over Eisai's maximum benefit. The offer is not valid for any other out-of-pocket costs, including medical administration charges. Supporting documentation must be submitted to the LEQEMBI Copay Assistance Program within 365 days of the date of treatment or the request will be rejected. In order to be eligible for reimbursement under the LEQEMBI Copay Assistance Program, claims for LEQEMBI must be submitted by provider to patient's private health insurance separately from other services and products. Additional instructions regarding required documentation in support of each claim will be provided by the program following confirmation of eligibility and enrollment. The LEQEMBI Copay Assistance Program will process eligible claims for patient out-of-pocket costs for LEQEMBI incurred for product administered up to 180 days prior to the date the patient is enrolled in the program.

Upon enrollment in the program, each patient will be issued a 16-digit virtual debit card. By enrolling in this program, the patient is providing consent for the LEQEMBI Copay Assistance Program to provide payment information for any approved claims, in the form of the 16-digit virtual debit card number, directly to the provider or alternate site of care identified on this enrollment form to be applied directly to the patient's out-of-pocket costs for LEQEMBI. By enrolling in the program and accepting payment, provider agrees to put the value of the patient LEQEMBI Copay Assistance Program directly toward the patient's out-of-pocket costs for LEQEMBI only. If provider has already received payment from the patient for the patient's out-of-pocket cost for LEQEMBI covered by the program, provider agrees to refund the amounts received back to the patient.

Eisai Patient Support Enrollment Form

Patient's name _____ DOB (MM/DD/YYYY) _____

Patient use (cont'd)

Patient and provider agree not to seek reimbursement for any or all of the benefit received by the patient through the LEQEMBI Copay Assistance Program. Patients and providers are responsible for complying with all requirements to disclose to insurance carriers and third-party payers the benefit received from the LEQEMBI Copay Assistance Program. The offer may not be combined with any other discount, coupon, free trial, or offer. Federal law prohibits the selling, purchasing, trading, or counterfeiting of this offer. Void outside the USA and where prohibited by law. Eisai Inc. reserves the right to rescind, revoke, or amend this offer at any time without notice. The value of this offer is not contingent on any prior or future purchases. This offer is solely intended to provide savings on the purchase of LEQEMBI. This offer may not be accepted by all providers or alternate sites of care. The LEQEMBI Copay Assistance Program is not an insurance program. There will be no membership fees.

LEQEMBI Copay Assistance Program patient attestation

Signature required for Copay Assistance Program enrollment

I understand that completing this form does not ensure that I will qualify for the LEQEMBI Copay Assistance Program. I have read and agree to comply with the terms and conditions for LEQEMBI Copay Assistance Program, set forth on this enrollment form and also available at EisaiPatientSupport.com/LEQEMBI.

My signature below certifies that I have completed all of the sections of the form completely, accurately, and to the best of my knowledge. I further certify (1) that I am not enrolled in any federal or state subsidized healthcare program, including Medicare, Medicaid, Medigap, VA, DOD, or TRICARE, that cover outpatient care, including for physician-administered or prescription drugs, or otherwise cover LEQEMBI; (2) that I have disclosed all of my current insurance coverage; and (3) that I will not seek reimbursement for my out-of-pocket expenses from any third party payers including from a flexible spending account, a healthcare savings account, or a health reimbursement account.

I agree to notify and shall be responsible for notifying the program administrator for the LEQEMBI Copay Assistance Program if I no longer meet the eligibility criteria for the LEQEMBI Copay Assistance Program. I also provide consent for the LEQEMBI Copay Assistance Program to provide payment information for approved claims, in the form of a 16-digit virtual debit card number, directly to the provider or alternate site of care identified on this enrollment form to be applied directly to my out-of-pocket costs for LEQEMBI.

I understand that the benefit available under the LEQEMBI Copay Assistance Program is limited to my out-of-pocket cost for LEQEMBI only. The program does not cover any other out-of-pocket costs, including medical administration charges.

I understand that Eisai Inc. reserves the right at any time and without notice to me to modify and/or discontinue any or all of the LEQEMBI Copay Assistance Program, including modification of eligibility criteria and immediate termination of assistance. I understand that I may decline to sign this form and decline to be considered for the LEQEMBI Copay Assistance Program.

Name of patient _____ Patient signature _____ Date _____

Name of authorized representative _____ Authorized representative signature _____ Date _____

Relation to patient _____