Eisai Neurology Patient Assistance Program

P.O. Box 632
Somerville, NJ 08876
(866) 694-2550
Fax (866)801-5631

Instructions:

- Healthcare Provider Section **must** be filled out completely.
- Healthcare Provider must sign application
  (ORIGINAL SIGNATURES ONLY-NO STAMPS OR PHOTOCOPIES)
- Mail or fax the completed original application to the following:

Eisai Neurology
Patient Assistance Program
P.O. Box 632
Somerville, NJ 08876
Fax: (866) 801-5631

- Patient section **must** be filled out completely.
- Patient **must** attach proof of income.
- Approved patients will receive a 90 day supply as written by their healthcare provider.
- All approved orders will be shipped to the healthcare provider.
- Approved patients are eligible for up to 1 year from date of approval.
- Patient must re-enroll annually

Application can be photo copied for future use. Please send a prescription.

All incomplete applications will be returned

Zonegran® and Banzel are available on the Eisai Neurology Patient Assistance Program in the following strengths:

Banzel 200MG & 400MG
Zonegran 25MG & 100MG

Eisai Inc. reserves the right to limit enrollment of patients to the Eisai Neurology Patient Assistance program at any time.

Eisai Neurology Patient Assistance Program

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Somerville, NJ 08876
Phone: (866) 694-2550
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Please read: Healthcare provider and patient sections must be completed. Application form may be mailed or faxed. Please note that this application is for Zonegran® or Banzel only.

HEALTHCARE PROVIDER (This section must be completed and signed by the provider.)

Name/Professional Designation: _____

Office Contact Person (Name and Title): _____

Phone number: _____

Fax number: _____

DEA# (if you do not have a DEA # Include copy of license) _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Healthcare Provider Certification: I certify that the information provided is complete and accurate to the best of my knowledge**.** My signature attests that medications received from Eisai for patient assistance are only for the use of the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, they will not be submitted for Medicare, Medicaid, or any third party reimbursement, nor returned for credit. By signing, I also agree that Eisai has the right to contact the patient directly to confirm receipt of medications, and to revise, change, or terminate this program at any time. Additionally, to the best of my knowledge, my patient meets Eisai's criteria for patient assistance, and does not have prescription drug insurance coverage (including Medicaid or other public programs) for Zonegran or Banzel. I certify that this prescription is medically indicated for this patient and I will be supervising the patient's treatment.

Original signature of licensed practitioner: _____ Date: _____

PATIENT (This section must be completed and signed by the patient.)

Proof of monthly income for all persons must be attached. Acceptable documents are: Monthly pay stubs (current within the last two months), Federal Income Tax form (1040, 1099) and/or Social Security/Disability statement.

Applicant is: □ Male □ Female

Name: _____

Address: _____

_____

City: _____

State/Zip code: _____

Phone: _____-_____-_____

Social Security Number: _____

Date of Birth: _____

Check only one:

- □ For Single Patients or Patients With No Dependents. Does the patient earn more than $25,000 per year? □ yes □ No
- □ For married Patients or Patients With Dependents. Does the household earn more than $40,000 per year? □ Yes □ No

Annual Household income:_____

Is the patient a resident of the United States, Puerto Rico or Virgin Island?

□ Yes □ No

Do you have prescription coverage in any government programs?
(This includes Medicaid, Medicare, Veteran's Administration and any other state or local program)

□ Yes □ No

Are you currently enrolled in a Medicare Part D prescription Drug plan?

□ Yes □ No

Do you have prescription coverage in any private programs?

□ Yes □ No

Please read the following, then sign: I certify that the information provided in this application is complete and accurate. I certify that I am uninsured and ineligible for any type of government or private prescription coverage for medications. I authorize Eisai Inc. and its agents to use my or my family's identifying information for the purpose of my participating in the Eisai Neurology Patient Assistance Program. I understand that any information that reveals my or my family's identity will not be used for any purpose other than that described above, unless I give written consent. I understand that Eisai Inc. reserves the right at any time and without notice to modify the application form or modify or discontinue this program and the related eligibility criteria. I understand that I am expected to seek any available state or government assistance before reapplying to the Eisai Neurology Patient Assistance Program and authorize the use of my social security number for identification purposes and record keeping. All personal information I provide will be kept confidential. Non-personal information (such as gender, location, or age) may be used to help Eisai Inc. assess this program, or create new programs.

Patient Signature _____ **Date** _____

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All information contained within this document is confidential.
01/12/2009