



BANZEL[®] Patients...Welcome to the Rx Outreach Medication Program!

Rx Outreach is pleased to partner with Eisai Pharmaceuticals to provide **BANZEL[®]** through our low cost medication program.

By enrolling in Rx Outreach, we can offer you an enhanced medication program that will enable you to get **BANZEL[®]**; in addition, have access to more than 230 other medications offered through the program.

Rx Outreach Program Benefits include:

- **Expanded Medication List** – Over 230 chronic medications, including BANZEL
- **Low Cost** - Most medications are available in 90- and 180-day supplies for a small administrative fee. Many of which offer a significant savings over your local retail pharmacy cash prices.
- **Enrollment Qualifications** - Individuals who are at or below 300% of the current FPL (\$35,310 for a single individual; \$72,750 for a family of four).
- **Easy Application Process** – simple enrollment form for the patient to complete; no supporting financial documentation is required.
- **Mailed Directly to Your Home** – Medications will be sent directly to the address of your choice.

What does this mean to you?

- Medication compliance; your medicine will be available to you.
- You have access to more than 230 other medications.
- Enrollment is easy, a one-page form; and no other paperwork is necessary.
- Your medications will be sent directly to you.

Just follow the easy steps below to get started:

1. Complete the **Patient Information** section on the BANZEL Enrollment Form on the next page.
2. Have your doctor complete the **Prescription** section on the Enrollment Form.
3. Fax or mail the completed form to Rx Outreach.

We are excited about the opportunity to be able to offer this program to you. This will enable us to continue to serve your medication needs through a safe, affordable and easy program. To learn more about Rx Outreach, please refer to the other sections on this web-site.

If you have any questions, please contact an Rx Outreach customer service representative at **877-318-9557**.



Enrollment Application

Banzel[®]
(rufinamide)

Patient Information

First Name	Last Name	
Address	Date of Birth <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Gender <input type="text"/>
Apt. #	Soc. Sec. # (optional) <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
City	Phone <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>	
State <input type="text"/> <input type="text"/>	Zip <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Annual Income: \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> # in Household <input type="text"/> <input type="text"/>
E-mail address: _____		
Food/Medications you are allergic to: _____		
Other Medications you are taking: _____		
Shipping address if different from above:		
Address _____ City _____ State _____ Zip _____		
I attest that the information provided in the application is complete and accurate. _____ (Signature required) (If advocate/guardian signing on behalf of the patient – please denote relationship)		

Patient Advocate/Guardian Contact: _____ Phone: () _____ - _____

Prescription

BANZEL STRENGTHS/DOSES AVAILABLE ON PROGRAM			Note: SHADED AREAS MUST BE COMPLETED.	
Check One	NDC	Strengths	QUANTITY (Required Field)	Admin Fee for Up to 90-day Supply
<input type="checkbox"/>	62856-582-52	BANZEL [®] 200mg tablet		\$0* *Supported by Eisai Inc.
<input type="checkbox"/>	62856-583-52	BANZEL [®] 400mg tablet		
<input type="checkbox"/>	62856-584-46	BANZEL [®] 40mg/mL – 460mL		

Directions: _____ Refills _____ # of times _____

ATTENTION NJ, NY & TN PRESCRIBERS: Please submit all prescriptions on official state security blanks. Do not use this form.

Physician Name: _____ DEA/ST Lic. # _____ (REQUIRED)

Phone Number: () _____ - _____ Fax Number: () _____ - _____

_____/_____/_____
SUBSTITUTION PERMITTED (Physician Signature) mm dd yyyy Dispense as Written

Disposition

Note: This form may be faxed to 1-888-430-9818 – Must be faxed from a physician’s office.

If Mailing: Send enrollment form to:

Rx Outreach
P.O. Box 66536
St. Louis, MO 63166-6536

Event Code
797

(877) 318-9557 / www.rxoutreach.org

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