SEARCHLIGHT SUPPORT®

Benefit Investigation and Enrollment Form

Fax this completed form to 1-888-782-6157 or mail to Searchlight Support®, P.O. Box 2930, Phoenix, AZ 85062
For assistance or additional information, call 1-844-SRCHLGT (1-844-772-4548), Monday–Friday, 8:00 AM–8:00 PM ET

Radicava® (edaravone) IV infusion 30mg/100mL

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last, Suffix) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ DOB (MM/DD/YYYY) _____

HOME PHONE _____ CELL PHONE _____

PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Cell Phone

2. 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.

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 (i.e., Medicare, Medicaid, VA, DoD, or other federal or state assistance programs) do not qualify for the Searchlight Support® Out-of-Pocket Assistance Program.

Please investigate benefits for: ☐ **SPECIALTY DISTRIBUTOR–BUY & BILL** ☐ **SPECIALTY PHARMACY–PRESCRIPTION** ☐ **HOME INFUSION** **If applicable, please attach prescription.**

Patients with no insurance will be contacted by Searchlight Support® for consideration in the Patient Assistance Program.

PRIMARY INSURANCE _____ GROUP/PLAN NAME _____

CARDHOLDER NAME _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____

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

SECONDARY INSURANCE _____ GROUP/PLAN NAME _____

CARDHOLDER NAME _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____

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

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.

3. PATIENT AUTHORIZATION (Patient must read the Patient Authorization on the Patient Copy and sign below.)

By signing below, I certify and acknowledge that I have read, understand, and agree to the Patient Authorization on page 3 of this form, to participate in the Searchlight Support® Program and to release my Protected Health Information to Mitsubishi Tanabe Pharma America, Inc. (as defined on page 3 of this form), supporting the access program as indicated on the Patient Authorization.

PATIENT SIGNATURE _____ DATE _____

If patient cannot sign, patient's Legal Representative must sign below.

PATIENT NAME _____ (Please Print)

LEGAL REPRESENTATIVE _____ (Please Print) BY _____ (Signature of Legal Representative)

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.

NATURE OF RELATIONSHIP TO PATIENT _____ DATE _____

WITNESS _____ (Optional) (Please Print) WITNESS SIGNATURE _____ ☐ NOTARY (Optional)

4. PRESCRIBER OFFICE INFORMATION (REQUIRED)

PRESCRIBER CONTACT NAME (First, Last) _____

PRACTICE NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # (Optional) _____ TAX ID # _____

STATE LICENSE # (Optional) _____ UPIN/NPI # _____

PREFERRED OFFICE CONTACT (IF DIFFERENT THAN ABOVE) _____

EMAIL _____

PHONE _____ FAX _____

5. PHYSICIAN SIGNATURE (REQUIRED) 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.

RADICAVA® (edaravone) 30 mg/100 mL injection for infusion

ICD-10: G12.21 Amyotrophic lateral sclerosis

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 Searchlight Support® 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® indicated above is medically necessary for this patient, and I have received authorization to release the medical and/or other patient information relating to this therapy to Mitsubishi Tanabe Pharma America, Inc., its affiliated companies, agents and representatives as specified in the Patient Authorization on page 3 of this form. I certify that, to the best of my knowledge, the patient and physician information in this form is complete, accurate, and consistent with applicable privacy regulations. If I am attaching a prescription, I certify that I have prescribed the product based on my professional judgment of medical necessity. I give Searchlight Support® permission to contact this patient to help obtain a signed Patient Authorization, if the patient has not provided their signature in Section 3 of this form.

PHYSICIAN SIGNATURE REQUIRED TO PROCESS PATIENT ENROLLMENT: I have reviewed the current RADICAVA® Prescribing Information and I will be supervising the patient's treatment. If I have attached a prescription, I authorize Searchlight Support® to act on my behalf to transmit the prescription to a contracted specialty pharmacy.

PHYSICIAN SIGNATURE _____ DATE _____

6. PREFERRED SITE OF INFUSION (OPTIONAL) (Do not complete fields below if information is the same as Prescriber Information)

☐ **Please provide Infusion Site Location Assistance if Primary and/or Secondary location is unknown**

Is this a VA site: ☐ **Yes** ☐ **No** **Site Name:** _____

If Primary Site of infusion is known, provide information below:

FACILITY NAME _____ CONTACT _____

FACILITY PHONE _____ FACILITY FAX _____

If Secondary Site of infusion is known, provide information below:

FACILITY NAME _____ CONTACT _____

FACILITY PHONE _____ FACILITY FAX _____

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

Healthcare Provider Disclaimer

By providing your information and information about your patient on the front of this Benefit Investigation and Enrollment Form, you are requesting to participate in Searchlight Support® and its programs. The information you provide will only be used by Mitsubishi Tanabe Pharma America, Inc. ("Mitsubishi 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 Mitsubishi Tanabe Pharma America at Searchlight Support® by mail, fax, email or telephone for the purposes of managing and delivering these services and programs. Our Privacy Policy, available at mt-pharma-america.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 Searchlight Support® and its service providers, including RxC Acquisition Company d.b.a. RxCrossroads by McKesson and TrialCard, Inc. (TrialCard). Please contact Searchlight Support® at 1-844-772-4548 if you wish to change your communication preferences.

Patient insurance benefit investigation is provided as a service by RxCrossroads by McKesson under contract for Mitsubishi Tanabe Pharma America. RxCrossroads by McKesson provides assistance 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 Searchlight Support® Out-of-Pocket Assistance Program is provided to eligible patients as a service by TrialCard under contract for Mitsubishi Tanabe Pharma America.

Verification of insurance coverage is ultimately the responsibility of the provider. Since reimbursement by payers is subject to many factors, RxCrossroads by McKesson and Mitsubishi Tanabe Pharma America do not represent or guarantee that payer reimbursement or any other payment or reimbursement of any kind will be made. RxCrossroads by McKesson and Mitsubishi Tanabe Pharma America 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. RxCrossroads by McKesson makes every effort to be accurate in the information provided; however, no representations or warranties are expressed or implied by RxCrossroads by McKesson and Mitsubishi Tanabe Pharma America regarding the accuracy or reliability of the information. RxCrossroads by McKesson or Mitsubishi 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. Providers and other users of this information resulting from benefit investigation services accept full responsibility for use of the service.

Mitsubishi 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 Searchlight Support®. Providers, not Mitsubishi Tanabe Pharma America, are responsible for the services they provide. The Searchlight Support® services have no value apart from the product.

Healthcare Provider Attestation for Searchlight Support® Patient Assistance Program

If the patient identified on page 1 of this form is determined to be eligible to participate in the Searchlight Support® 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 Searchlight Support® Benefit Investigation and Enrollment Form for RADICAVA® (edaravone).

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

Mitsubishi Tanabe Pharma America

Patient Copy

Provider Instructions

1. **Instruct the patient to read this page and sign the Authorization in Section 3 on page 1 of the Benefit Investigation and Enrollment Form for RADICAVA® (edaravone).**
2. **Give the patient this page, a copy of page 1 of the Searchlight Support® Benefit Investigation and Enrollment Form, and a copy of the Patient Acknowledgement.**

PATIENT AUTHORIZATION

My signature on page 1 of the Benefit Investigation and Enrollment Form (the "Form") for RADICAVA® serves as confirmation that I authorize each of my physicians and pharmacists, including any specialty pharmacy and/or home infusion provider which receives my prescription for RADICAVA® 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, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Mitsubishi Tanabe Pharma America, Inc., its affiliated companies, agents and representatives (together, "Mitsubishi Tanabe Pharma America"), including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access and assistance programs for Healthcare Providers and patients (Searchlight Support®) for the purposes described below.

I specifically authorize Mitsubishi Tanabe Pharma America 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 Searchlight Support® programs, including potential enrollment in the Searchlight Support® Out-of-Pocket Assistance Program if I am an eligible, commercially insured patient with insurance coverage for RADICAVA®, or Searchlight Support® 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®; (iii) to verify, investigate, assist with, and coordinate my coverage for RADICAVA® with my Insurers; (iv) to coordinate prescription fulfillment, including triaging my information and my prescription to a specialty pharmacy and/or home infusion provider; (v) to assist with analyses related to the quality, efficacy, and safety of RADICAVA®, and patient access to and treatment compliance with RADICAVA®; (vi) to send me marketing information related to my condition, my treatment, or related products or services that might be of interest to me; (vii) to contact me occasionally to obtain my feedback for market research purposes about my treatment, my condition, or my experience with RADICAVA®, Mitsubishi Tanabe Pharma America and/or Searchlight Support®; and (viii) to contact me about other products and services offered by Mitsubishi Tanabe Pharma America. Mitsubishi Tanabe Pharma America may use my Protected Health Information to contact me for any purpose described in this Authorization by mail, email, phone calls, voice messages, interactive voice recordings that may include use of autodialers or artificial or prerecorded voice messages, and SMS text messages (data rates may apply). Marketing communications will include information about how I can opt-out of receiving future communications. I understand that my participation in the Searchlight Support® Program will not be affected if I opt-out.

I understand that pharmacies that ship my medication may be paid to share this information with Searchlight Support® 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 Mitsubishi Tanabe Pharma America for any other purpose than described in this 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 Mitsubishi Tanabe Pharma America 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 Mitsubishi Tanabe Pharma America collects, uses, and discloses personal information, I can visit mt-pharma-america.com/privacy-policy.

I understand that I am not required to sign the front of the Benefit Investigation and Enrollment Form for RADICAVA®. My decision whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I do not sign the Authorization in Section 3 on page 1 of this Form, or cancel (revoke) my Authorization later, I understand that this means I will not be able to participate or receive assistance from Searchlight Support®.

This Authorization will remain in effect for 5 years from the date of my signature, or until I am no longer participating in Searchlight Support® 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 Searchlight Support®, P.O. Box 2930, Phoenix, AZ 85062. 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 Mitsubishi Tanabe Pharma America. Cancelling this authorization will not affect the ability of Mitsubishi Tanabe Pharma America 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 Searchlight Support® 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 Mitsubishi Tanabe Pharma America.

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

Mitsubishi Tanabe Pharma America

PATIENT ACKNOWLEDGMENT

My signature on page 1 of the Benefit Investigation and Enrollment Form (the "Form") for RADICAVA® (edaravone) serves as confirmation of the following:

- If I am eligible to participate in the Searchlight Support® Patient Assistance Program (the "Program"), I agree to notify Searchlight Support® if my insurance situation changes, and I understand that upon obtaining health insurance, I will no longer be eligible to participate in the Program and that Searchlight Support® Patient Assistance Program medication will no longer be dispensed to me.
- My eligibility to receive assistance in the Program 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 Searchlight Support® Patient Assistance Program 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® medication provided at no charge by the Program and that I will not seek to have free medication or any associated costs counted towards my Medicare Part D True out-of-pocket (TrOOP) costs for prescription drugs.
- I understand and agree that the Program covers only the cost of RADICAVA® and not the cost of any infusion services or Healthcare Provider visits, which are my sole responsibility.
- I understand that Searchlight Support® has the right to verify my eligibility, including the right to audit any information provided on page 1 and to contact me to confirm receipt of medications.
- I also understand that the Program may be revised, changed or terminated at any time without notice.

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

Mitsubishi Tanabe Pharma America, Inc.
525 Washington Boulevard, Suite 400
Jersey City, NJ 07310

Mitsubishi Tanabe Pharma America