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

Patient Authorization Form for RADICAVA ORS®

INSTRUCTIONS

- **If patient has not already signed a Benefit Investigation and Enrollment Form for RADICAVA ORS® (edaravone), patient must read this Patient Authorization and sign on page 3 to authorize *JourneyMate Support Program*™ services.**
- **Patient should retain a copy of this form for their records.**

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 Patient Authorization 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 full Prescribing Information and Patient Information available at www.radicavaors.com.

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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

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Tanabe Pharma America

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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 RADICAVA ORS® 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 1, 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 1.

☐ 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 1.

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

FAX COMPLETED FORM TO 1-888-782-6157.

Please see the full Prescribing Information and Patient Information available at www.radicavaors.com.

Tanabe Pharma America, Inc.
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Jersey City, NJ 07310

Tanabe Pharma America