Exservan™ (riluzole) oral film

Prescription and Enrollment Form

Fax this completed form to 1-855-905-5938. For assistance or additional information, call 1-855-743-9275, Monday–Friday, 8:00 AM–8:00 PM ET

IMPORTANT: PATIENT AUTHORIZATION INFORMATION

Patient Authorization **IS REQUIRED** to enroll your patient in the Out-of-Pocket Assistance and educational programs. Please use the following options:

1. **If the patient or Legal Representative is available in your office, they may sign the Authorization on PAGE 3 after reading page 4**
2. If the patient is unavailable, PANTHERx Rare Pharmacy will contact the patient and provide instructions for obtaining the patient's electronic signature on a Patient Authorization Form

PATIENT NAME _____ **DOB** (MM/DD/YYYY) _____

1. PRESCRIBER OFFICE INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____ TITLE (ie, MD, DO, PA, NP) _____

SPECIALTY _____ PRACTICE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

UPIN/NPI # _____

PREFERRED OFFICE CONTACT (IF DIFFERENT THAN ABOVE) _____

EMAIL _____ PHONE _____ FAX _____

2. PHARMACY INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy# 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 (ie, Medicare, Medicaid, VA, DoD, or other federal or state assistance programs) do not qualify for the Out-of-Pocket Assistance Program for EXSERVAN™.

INSURANCE NAME _____ CARDHOLDER NAME _____

RELATIONSHIP TO CARDHOLDER _____ PHARMACY HELP DESK PHONE _____

MEMBER ID # _____ GROUP ID # _____ PCN # _____ Rx BIN # _____

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. CLINICAL INFORMATION

DIAGNOSIS CODE(S): ☐ G12.21: Amyotrophic lateral sclerosis (ALS) ☐ Other _____

Patient is experiencing difficulty swallowing: ☐ Yes – Details _____ ☐ No

Prior or current treatment with riluzole therapy: ☐ Yes – Details _____ ☐ No

Other prior treatments and dates of use: _____

Current Medications: ☐ Yes – Please include a current medication list ☐ None

Please include documentation to support the information above.

4. FREE TRIAL ENROLLMENT – Patient must meet Eligibility Requirements and comply with the Terms and Conditions on page 2.

EXSERVAN™ (riluzole) 50 mg oral film, 30-day supply (60 pouches)

Directions: ☐ Dissolve 50 mg by mouth twice daily, taken at least 1 hour before or 2 hours after a meal ☐ Other: _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED BELOW TO VALIDATE PRESCRIPTION: By signing below, I certify that this patient meets the Eligibility Requirements for the Free Trial Program for EXSERVAN™ and is aware of the Terms and Conditions included on page 2.

5. PRESCRIPTION FOR EXSERVAN™

EXSERVAN™ (riluzole) 50 mg oral film, 30-day supply (60 pouches) Refill: _____

Directions: ☐ Dissolve 50 mg by mouth twice daily, taken at least 1 hour before or 2 hours after a meal ☐ Other: _____

By signing this form, I am indicating a prescribing decision has been made. In addition, I am certifying treatment with EXSERVAN™ 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. 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 including a prescription, I certify that I have prescribed the product based on my professional judgment of medical necessity. I give PANTHERx permission to contact this patient to help fulfill the prescription.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO PROCESS PATIENT ENROLLMENT: I have reviewed the current EXSERVAN™ Prescribing Information, and I will be supervising the patient's treatment. I authorize PANTHERx to act on my behalf to fill this prescription. I have read, understand, and agree to the Healthcare Provider Disclaimer on page 2.

PHYSICIAN SIGNATURE _____ DATE _____

Healthcare Provider Disclaimer

By providing your information and information about your patient on the front of this Prescription and Enrollment Form, you are requesting to participate in PANTHERx Rare Pharmacy (PANTHERx) support for EXSERVAN™ (riluzole) oral film. 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 1-855-743-9275. You agree to be contacted by Mitsubishi Tanabe Pharma America at PANTHERx by mail, fax, 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 PANTHERx. Please contact PANTHERx at 1-855-743-9275 if you wish to change your communication preferences.

Patient insurance benefit investigation is provided by PANTHERx. PANTHERx 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 Prescription and Enrollment Form, following your determination of medical necessity. Patient out-of-pocket cost support through the Out-of-Pocket Assistance Program for EXSERVAN™ is provided to eligible patients as a service by PANTHERx 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, PANTHERx 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. PANTHERx 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. PANTHERx makes every effort to be accurate in the information provided; however, no representations or warranties are expressed or implied by PANTHERx and Mitsubishi Tanabe Pharma America regarding the accuracy or reliability of the information. PANTHERx 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 PANTHERx. Providers, not Mitsubishi Tanabe Pharma America, are responsible for the services they provide. PANTHERx services have no value apart from the product.

Eligibility Requirements for Patient Participation in the Free Trial Program for EXSERVAN™ oral film

- The prescriber has provided a signed, completed Prescription and Enrollment Form for EXSERVAN™ with the Free Trial Enrollment Section completed to PANTHERx
- The patient has been prescribed EXSERVAN™ oral film

By participating in the Free Trial Program for EXSERVAN™, you acknowledge that your patient currently meets the Eligibility Requirements and that your patient is aware of the Terms & Conditions described below.

Terms and Conditions for the Free Trial Program for EXSERVAN™

- The patient's healthcare provider must provide a signed, completed Prescription and Enrollment Form for EXSERVAN™ with the Free Trial Enrollment Section completed to PANTHERx
- The Program is limited to 1 (one) 30-day supply per patient per lifetime and is not transferable
- Patient must be new to EXSERVAN™
- The Program is available to patients who have private, commercial health insurance, government coverage, or no insurance coverage
- Patient must not seek reimbursement or compensation, in whole or in part, from any third-party payer, including government health insurance (including Medicare, Medicaid, VA, DoD, or other federal or state assistance programs), a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA)
- Patient must not in any way report or apply the value of the free product provided under this Program toward any insurance benefit out-of-pocket spending calculations, including Medicare Part D true out-of-pocket spending (TrOOP)
- This offer may not be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription
- Patient must be a citizen or a permanent resident of the US or its territories and reside in the US or its territories where a no-cost product trial offer is not prohibited
- Offer good only in the US and its territories
- Patient must be over the age of 18
- There is no income requirement
- This Program is not health insurance
- There is no guarantee of continuous accessibility to EXSERVAN™ after the Program ends
- There is no obligation to continue EXSERVAN™
- This offer is not conditioned on any past, present, or future purchase, including refills
- By participating in this Program, the patient confirms that they have read, understood, and agree to the Program Terms and Conditions and that the patient is giving permission for information related to their participation in this Program to be shared with their healthcare provider(s)
- Patient understands that they will be asked to provide personal information that may include the patient's name, address, phone number, email address, and information related to prescription medication insurance and their treatment. This information is necessary to permit Mitsubishi Tanabe Pharma America, Inc. and companies that work with Mitsubishi Tanabe Pharma America, Inc. including our affiliates and our service providers, to fulfill the patient's request to enroll in the Program
- Mitsubishi Tanabe Pharma America, Inc. will not share the patient's information with any third parties except as required for administration of the Program or as required by law
- No membership fees
- Patient may discontinue their participation in the Program any at time by calling 1-855-743-9275
- Mitsubishi Tanabe Pharma America, Inc. has the right to modify, alter, or cancel the Program at any time without prior notification

Please see full Prescribing Information, including Patient Important Safety Information (ISI) for EXSERVAN™, available at exservan.com.

This page is an option for obtaining Patient Authorization for the Out-of-Pocket Assistance and educational programs.

1. **Instruct the patient to read page 4 and sign the Authorization below.**
2. **Fax this page (with patient signature) along with the completed Prescription and Enrollment Form. See fax instructions on page 1.**
3. **Give the patient page 4 and a copy of this page.**

PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last, Suffix) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ DOB (MM/DD/YYYY) _____ GENDER ☐ M ☐ F

HOME PHONE _____ MOBILE PHONE _____

PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Mobile Phone

ADDITIONAL CONTACT NAME _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____ MOBILE PHONE _____

PREFERRED NUMBER TO CALL ☐ Home Phone ☐ Mobile Phone

MARKETING COMMUNICATIONS AND MARKET RESEARCH TEXT MESSAGE OPT-IN

☐ YES - I agree to receive updates and information about ALS and treatment options 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. By opting in, I authorize JourneyMate to deliver SMS text messages using an automatic telephone dialing system and I understand that I am not required to opt-in as a condition of purchasing any property, goods, or services. Read Text Message Terms and Conditions (exservan.com/mobile) and Privacy Policy (exservan.com/privacy-policy).

☐ NO - I do not agree to receive marketing communications via SMS text messages as described above.

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 4, to receive product access services and to release my Protected Health Information to Mitsubishi Tanabe Pharma America (as defined), for the purposes described in this Authorization.

PATIENT SIGNATURE _____ DATE _____

☐ 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 4.

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

PATIENT AUTHORIZATION

My signature on page 3 serves as confirmation that I authorize each of my physicians and pharmacists, including PANTHERx Rare Pharmacy (PANTHERx) which receives my prescription for EXSERVAN™ (riluzole) oral film 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 Mitsubishi Tanabe Pharma America, Inc., its affiliated companies, agents and representatives (together, "Mitsubishi Tanabe Pharma America" or "MTPA"), including vendors providing relevant patient education programs and other service providers supporting product access programs for Healthcare Providers and patients for the purposes described below ("product access services").

PRODUCT ACCESS SERVICES ENROLLMENT

I specifically authorize MTPA 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 product access services, including potential enrollment in the Free Trial Program for EXSERVAN™ if I am eligible, the Out-of-Pocket Assistance Program for EXSERVAN™ if I am an eligible, commercially insured patient with insurance coverage for EXSERVAN™; (ii) to provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to EXSERVAN™ 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 EXSERVAN™; (iv) to assist with analyses related to the quality, efficacy, and safety of EXSERVAN™ and patient access to and treatment compliance with EXSERVAN™; and (v) to enhance and improve the product access services. MTPA 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 PANTHERx at 1-855-743-9275 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 EXSERVAN™.

MARKETING COMMUNICATIONS AND MARKET RESEARCH OPT-IN

Checking the box below my signature on page 3 serves as confirmation that I authorize MTPA 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 EXSERVAN™ and/or MTPA; and (iii) to contact me about other products and services offered by MTPA. MTPA may contact me for these purposes by mail, email, and telephone. If I check the YES box on page 3, MTPA 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 the pharmacy that ships my medication may be paid to share information with PANTHERx 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 MTPA 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 MTPA 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 MTPA collects, uses, and discloses personal information, I can visit mt-pharma-america.com/privacy-policy. I understand that I am not required to sign this Patient Authorization for EXSERVAN™. My decision whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I do not sign the Authorization above, or cancel (revoke) my Authorization later, I understand that this means I will not be able to receive product access services. However, I understand I may call PANTHERx 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 benefits 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 receiving product access 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 PANTHERx Rare Pharmacy, 24 Summit Park Drive, Pittsburgh, PA 15275. 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 MTPA. Cancelling this Authorization will not affect the ability of MTPA 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 product access services for EXSERVAN™ are 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 MTPA.

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