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) _____ SEX ☐ M ☐ F

ADDRESS _____

CITY _____ STATE _____ ZIP _____ DOB (MM/DD/YYYY) _____

SSN # _____ E-MAIL _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable or provide a copy of insurance cards)

☐ **BENEFIT INVESTIGATION ONLY—Product order will NOT be placed at this time.**

Please investigate benefits for: ☐ **SPECIALTY DISTRIBUTOR—BUY & BILL** ☐ **SPECIALTY PHARMACY—PRESCRIPTION** ☐ **HOME INFUSION**

Patients with no insurance for RADICAVA™ (edaravone) IV infusion should complete Section 3 for consideration in the Patient Assistance Program.

PRIMARY INSURANCE _____ CARDHOLDER NAME _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____

PRESCRIPTION DRUG INSURER _____ CARD/BIN # _____ PHONE _____

☐ Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.

3. PATIENT FINANCIAL INFORMATION

Only for patients with no insurance, or no insurance coverage for RADICAVA™, who have exhausted all appeal options, and who want to participate in the Patient Assistance Program. Based on eligibility requirements. Restrictions apply. See Patient Assistance Program Brochure for terms and conditions.

HOUSEHOLD SIZE _____ TOTAL YEARLY COMBINED HOUSEHOLD INCOME* (before taxes) _____

*Note: Must include proof of income consisting of all gross income such as a copy of most recent Federal tax return, W-2 or copy of recent pay stub, copy of Social Security check or awards letter, etc.

INCOME SOURCES: Salary/Wages $ _____ Alimony/Child Support $ _____ Pension/Retirement $ _____

Disability $ _____ Social Security $ _____ Unemployment/Work $ _____

TOTAL PATIENT HOUSEHOLD ASSETS (excludes home and car): $ _____

☐ Check here if you are a citizen or permanent resident of the U.S. or its territories and reside in the U.S. or its territories.

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____

STATE LICENSE # _____ UPIN/NPI # _____

By signing this form, you are certifying treatment with RADICAVA™ indicated above is medically necessary for this patient and you have received authorization to release the medical and/or other patient information relating to this therapy to MT 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 and regulations. 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 5 of this form.

PRESCRIBER SIGNATURE _____ DATE _____

5. 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 MT Pharma America, Inc. (as defined on page 3 of this Form), supporting the access program as indicated on the Patient Authorization. By signing below I also certify that the information provided in Section 3 of this form is accurate and complete.

PATIENT SIGNATURE _____ DATE _____

If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME _____
(Please Print)

AUTHORIZED REPRESENTATIVE _____ BY _____
(Please Print) (Signature of authorized representative)

RELATIONSHIP TO PATIENT _____ DATE _____

6. PRODUCT ACQUISITION INFORMATION (REQUIRED)

☐ **SPECIALTY PHARMACY—PRESCRIPTION BASED (Prescription billed directly to patient's health plan)**

☐ **SPECIALTY DISTRIBUTOR—BUY & BILL**
PREFERRED SPECIALTY DISTRIBUTOR ☐ ASD ☐ Besse ☐ Cardinal ☐ McKesson Plasma and Biologics ☐ McKesson Specialty Health

Account information for Buy & Bill:

ACCOUNT # _____ PURCHASE ORDER # (if applicable) _____

ACCOUNT TYPE ☐ Provider Office ☐ Other (clinic) ☐ 340B ☐ PHS ☐ VA ☐ Home Health ☐ Freestanding Infusion Center

ACCOUNT HOLDER NAME (First, Last) _____

PHONE _____

E-MAIL _____

NOTE: Provider will be invoiced for RADICAVA™ purchased from the specialty distributor at the contracted rates under the provider's agreement or rates quoted at the point-of-sale. Provider is financially responsible for, and agrees to pay, the distributor all invoiced charges for products ordered by provider. Each invoice will be due and payable by provider within the payment terms offered by the distributor on the date-of-order.

7. PRESCRIPTION INFORMATION (REQUIRED) SPECIAL NOTE: 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 **DIAGNOSIS:** G12.21 Amyotrophic lateral sclerosis (progressive spinal muscle atrophy)

DIRECTIONS: ☐ **STARTER DOSE:** Once daily 60 mg/200 mL, 60-minute IV infusion for 14 consecutive days, followed by cessation for 14 days

☐ **MAINTENANCE:** Once daily 60 mg/200 mL, 60-minute IV infusion for any 10 of 14 days, followed by cessation for 14 days

REFILLS: _____ **QUANTITY:** _____ (Maximum Quantity: 7 Days Supply)

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION (NO STAMPS): I have reviewed the current RADICAVA™ Prescribing Information and I will be supervising the patient's treatment. I authorize Searchlight Support™ to act on my behalf to transmit this prescription to a contracted specialty pharmacy.

PRESCRIBER SIGNATURE (Dispense as Written) _____ DATE _____

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

☐ **Please provide Infusion Site Location Assistance for this patient**

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home infusion/Infusion Provider Company ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____ UPIN/NPI # _____

PRACTICE/FACILITY NAME _____ UPIN/NPI # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

CONTACT NAME _____ TAX ID # _____

Please see full Prescribing Information, including Patient Information, available at www.radicava.com.

Clear Form Print Form

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 MT Pharma America, Inc., 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 MT Pharma America, Inc., at Searchlight Support™ by mail, fax, e-mail or telephone for the purposes of managing and delivering these services and programs. Our Privacy Policy, available at www.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 read, understand, and agree to these terms and agree to receive program-related communications from Searchlight Support™ and its service providers, including McKesson Specialty Health. 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 McKesson Specialty Health (MSH) under contract for MT Pharma America, Inc. MSH 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.

Verification of insurance coverage is ultimately the responsibility of the provider. Since reimbursement by payers is subject to many factors, MSH and MT Pharma America, Inc., do not represent or guarantee that payer reimbursement or any other payment or reimbursement of any kind will be made. MSH and MT Pharma America, Inc., 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. MSH makes every effort to be accurate in the information provided; however, no representations or warranties are expressed or implied by MSH and MT Pharma America, Inc., regarding the accuracy or reliability of the information. MSH or MT Pharma America, Inc., or its agents or employees shall not be liable legally, financially, or otherwise, or 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.

MT Pharma America, Inc., 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 MT Pharma America, Inc., 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 third-party coverage for this prescription of RADICAVA™ (edaravone) IV infusion through, 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™.

Please see full Prescribing Information, including Patient Information, available at www.radicava.com.

MT Pharma America

Patient Copy

Provider Instructions

1. **Instruct the patient to read this page and sign the Authorization in Section 5 on page 1 of the Benefit Investigation and Enrollment Form for RADICAVA™ (edaravone) IV infusion.**
2. **Give the patient this page and a copy of page 1 of the Searchlight Support™ Benefit Investigation and Enrollment Form.**

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 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 MT Pharma America, Inc., its affiliated companies, agents and representatives, 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™) (together, "MT Pharma America, Inc.") for the purposes described below.

I specifically authorize MT Pharma America, Inc., 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™, the Searchlight Support™ Connect Program if I am an eligible, commercially insured patient when there is a delay in securing commercial health plan coverage for RADICAVA™ or Searchlight Support™ Patient Assistance Program, if I have no insurance, or no insurance coverage for RADICAVA™ 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 (v) to assist with analyses related to the quality, efficacy, and safety of RADICAVA™, and patient access to and treatment compliance with RADICAVA™. 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 MT Pharma America, Inc., for any other purpose than described in this Form unless permitted by law or unless information that specifically identifies me is removed and therefore "de-identified." I understand that MT Pharma America, Inc., 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 MT Pharma America, Inc., collects, uses, and discloses personal information, visit www.mt-pharma-america.com/privacy-policy.

If I am eligible to participate in the Searchlight Support™ Patient Assistance Program (the "Program"), I understand that upon receiving health plan coverage for RADICAVA™, 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, 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. 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.

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 5 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. 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 MT Pharma America, Inc., but this will not affect the ability of MT Pharma America, Inc., 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 MT Pharma America, Inc.

Please see full Prescribing Information, including Patient Information, available at www.radicava.com.

MT Pharma America