26790

ONCE-A-DAY ARICEPT (donepezil HCl)

PATIENT ASSISTANCE PROGRAM QUALIFICATION FORM
FAX FORM TO 1-800-226-2059
Or mail to ARICEPT® PATIENT ASSISTANCE PROGRAM
1480 Arthur Avenue, Suite D, Louisville, CO 80027

Please print using capital letters A B C D E 1 2 3 Shade bubbles like this ● not like this ⊘ ✓ CSN

PATIENT'S INFORMATION

First Name | M.I. | Last Name

Address | ( ) Phone | O Male O Female

City | State | Zip | Date of Birth (MM-DD-YY)

1. ***For Single Patients or Patients With No Dependents.*** Does patient earn more than $25,000 per year? O Yes O No
2. ***For Married Patients or Patients With Dependents.*** Does patient earn more than $40,000 per year? O Yes O No
3. **Patient's Site of Care, select one:** O Home O Family Member's Home O Assisted Living O Long Term Care Facility O Nursing Home
   O Other _____
4. **Patient's insurance and prescription drug coverage, partial or full:** O Medicare O Medicaid O Medicaid QMB O Uninsured
5. **Other patient coverage, please select all that apply:**

O Medicare Managed Care O Includes Rx
O State/Local Government Program O Includes Rx
O Federal Program O Includes Rx
O Private Insurance/HMO O Includes Rx
O Private Foundation O Includes Rx
O Other Rx Program

If Rx included, please explain coverage

If RX coverage, name of insurance carrier

Specify other RX Program

PATIENT/APPLICANT DECLARATION:

I understand that completing this form does not ensure that I will qualify for this program. I verify that the information provided in this qualification form is complete and accurate. I agree to notify the Aricept Patient Assistance Program if I obtain prescription drug coverage or if I no longer meet the income criteria.

I authorize the program to obtain and disclose information from my prescribing physician, caregiver, and other sources, as deemed necessary, to ensure the accuracy and completeness of this application and to provide services through this program.

I understand that the program administrators reserve the right any time and without notice to modify the application form, modify or discontinue any or all of the program and related eligibility criteria; or terminate assistance provided by the program at any time.

I understand that personal identifying information provided on this form will be available to Eisai Inc., Pfizer Inc, their affiliated companies and their subcontractors on a need to know basis for the purposes of administering the program.

Patient or Caregiver Signature | Date

PHYSICIAN'S INFORMATION

First Name | M.I. | Last Name

Address 1 | Address 2

Address 3 | Specialty

City | State | Zip

( ) Phone | Physician's Email

( ) Fax | State License #: Place an ✳ under all alphabetical characters

ARICEPT® DOSAGE

This section of the form will serve as the Aricept® Prescription

Quantity: 90 tablets
(1 bottle of 90 tablets)

O 5 mg tablets O 10 mg tablets
O QD sig - 1 tablet daily
O QHS sig - 1 tablet every bedtime
O Other _____

PHYSICIAN'S/PRESCRIBER ATTESTATION:

I hereby request Aricept for the above named patient.

To the best of my knowledge this patient has no medical insurance (including Medicaid or other public programs) for this prescription. I verify that the information provided is complete and accurate to the best of my knowledge. I certify that this prescription is medically indicated for this patient and that I will be supervising the patient's treatment. I understand that the medication prescribed above shall be sent to my office for dispensing to this patient, and I certify that the medication requested above shall only be used to treat this patient and I shall not seek reimbursement for this medication from the patient or any third party.

I have received a signed Patient Authorization to Disclose Protected Health Information from the above named patient.

Physician/Prescriber's Original Signature | Date

Eisai Inc. and Pfizer Inc. reserve the right to limit enrollment of patients to the Aricept Patient Assistance Program at any time. January 2004.

604

Authorization To Disclose Information About Me In The Aricept® (Donepezil HCl Tablets) Patient Assistance Program

To the Patient: Eisai Inc. and Pfizer Inc. together offer the Aricept® (donepezil HCl tablets) Patient Assistance Program (the "Program") to help patients who qualify obtain Aricept at no cost. In order to determine your eligibility for the Program and to administer you participation in the Program if you are accepted, Eisai and Pfizer, along with their affiliated companies and contractors who administer the Program, need to obtain certain information about you from your doctor. Eisai and Pfizer agree that they will only use this information to determine your eligibility for this Program, to administer the Program, and to account for your withdrawal if you decide to stop participating in this Program. Please complete this Authorization for the disclosure of information in connection with the Program, sign and date it, and return it to your doctor.

I request and authorize my doctor, ("Doctor"),

to give Eisai and Pfizer, including representatives and contractors who work on behalf of Eisai and Pfizer in this Program, information about me and my medical condition, which is necessary to determine my eligibility for the Program and for my continuing participation in the Program if I am accepted. The type of information that may be given under this authorization includes:

- My name and birth date
- My address and telephone number
- Financial information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, which indicates that the use of Aricept is medically necessary

I know that I need to sign this authorization to take part in this Patient Assistance Program. If I do not sign this authorization, my decision will not affect my ability to obtain treatment from a health care provider of my choice or to seek payment for treatment from other sources. I also know that I can cancel this authorization at any time by writing to my Doctor at:

If I cancel this authorization, then my Doctor will stop providing Eisai and Pfizer, and their representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

I understand that once my Doctor gives Eisai and Pfizer information about me based on this authorization, federal privacy laws may not prevent Eisai and Pfizer from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into the Aricept Patient Assistance Program.

This authorization will expire on (1) year after the date it is signed, below, or one (1) year after the last date I receive Aricept under the Program, whichever is later.

Patient or Personal Representative of Patient

Patient First Name M.I.

Patient Last Name

Patient Signature _____ Date ___/___/_____

Authority to sign on behalf of Patient (if applicable) _____

[Keep a copy of this signed form for your records]