How to complete this enrollment form

Patient (or legal authorized representative) **must do the following:**

- Read and sign the patient authorization (section 1), and fill out sections 2 through 5

The prescribing healthcare provider must do the following:

- Complete sections 6 and 7, including prescription with prescriber's signature

How to submit this enrollment form

- Submit completed form online at www.OtsukaPatientAssistance.com, by fax at **1-844-727-6274**, or by mail at **Otsuka Patient Assistance Foundation, PO Box 220248, Charlotte, NC 28222-0248**

*For additional assistance, please contact the Dedicated Patient Coordinator by dialing **1-855-727-6274**.*

To be completed by the patient

SECTION 1. PATIENT AUTHORIZATION

I (patient and/or legal authorized representative) authorize that my protected health information (PHI) (or the patient's PHI) may be sent to the Otsuka Patient Assistance Foundation, Inc. (hereafter referred to as the Foundation), disclosed to and reviewed by Otsuka and its authorized representatives and vendors, as described above, and disclosed to others by the Foundation, including:

- Information provided on this form
- My healthcare records related to my treatment and condition(s)
- Payer-related information received from my health insurer
- Prescription, fulfillment, and shipment information from pharmacies or other relevant sites of care
- Hospitalization details and information to help support my transition of care

In addition, I (or I on behalf of the patient) authorize the Foundation to use my information for internal data collection and reporting purposes, to track coverage, cost-share and payer-related trends, for utilization of the Foundation offerings, and to assess ongoing and future needs of patients who are prescribed Otsuka products.

I acknowledge that my (or the patient's) household income and the number of people in my (or the patient's) household have been accurately reported on this form to the best of my ability and knowledge. In the event I am unable to provide financial documentation, I authorize the use of my social security number and/or additional demographic information to access my credit information and information derived from public and other sources to estimate my income to determine eligibility.

My authorization and notice of release will remain in effect for two (2) years from the date of my signature. I understand that I may be requested to provide my written consent on an annual basis in an effort to support continued access to my medication. Signing this consent form is voluntary. I understand I can refuse to sign this form and it will not affect the start, continuation, or quality of my treatment from my healthcare provider.

*After you have signed this consent, you may withdraw it by calling the Foundation at **1-855-727-6274** or by sending a written notice to the Foundation at **Otsuka Patient Assistance Foundation, PO Box 220248, Charlotte, NC 28222-0248**. If you choose not to sign this authorization or you withdraw it after signing this form, the Foundation will not be able to provide you with support after the date of your revocation.*

Patient Name or Legal Authorized Representative	Relationship to Patient	Patient's DOB
		/ /

sign here

Signature of Patient or Legal Authorized Representative	Date
X	/ /

Patient Assistance Foundation

Enrollment Form

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To be completed by the patient

SECTION 2. DEMOGRAPHIC INFORMATION (If copy of demographic/fact sheet is attached, please still fill out name and DOB.)

First name: Last name: MI:

Address:

City: State: Zip:

SSN: - - Gender: M F

DOB: / / Preferred language: Email:

Phone: ( ) - Cell phone: ( ) -

Please call caregiver. Relationship:

Caregiver name:

Phone: ( ) - Cell phone: ( ) -

SECTION 3. INSURANCE INFORMATION

I do not have insurance (skip to section 4).

I have insurance. Please fill out the section below **OR** attach copies of insurance and prescription cards.

Medical Card

Payer name: Plan name:

Phone: ( ) - Policyholder name:

Member ID: Group #: Policyholder DOB: / /

Prescription Card

Member ID: BIN: PCN:

SECTION 4. INSURANCE ELIGIBILITY INFORMATION

Do you have insurance or any prescription drug coverage? (If YES, please complete section 3.) Yes No

Have you been denied coverage by a health or medical insurance provider? Yes No

Are you enrolled in Medicare, Medicaid, Veterans Affairs, or TRICARE? Yes No

Have you been denied Medicaid? Yes No

Are you in the process of enrolling in Medicare Part D? Yes No

Do you live in the United States? Yes No

Do you have a physical address (ie, not a PO box) to receive shipment? Yes No

SECTION 5. FINANCIAL ELIGIBILITY INFORMATION

Please complete the information below for income and household size.

Annual household income: $

Number of persons living in household, including yourself:

Annual prescription costs (required if you have insurance): $

Patient Assistance Foundation

Enrollment Form

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To be completed by the prescribing healthcare provider

SECTION 6. PRESCRIBER INFORMATION

☐ Cardiologist ☐ Internal medicine ☐ Nephrologist ☐ NP ☐ Oncologist ☐ PA ☐ Psychiatrist

☐ Other:

Name: Contact name:

State license #: TIN: NPI#:

Site name:

Address:

City: State: Zip:

Contact direct phone: ( ) - Contact fax: ( ) -

Contact email:

SECTION 7. PRESCRIPTION INFORMATION

Patient's first name: Patient's last name:

Patient's DOB: / /

A. DIAGNOSIS CODE

ICD code:

B. DOSAGE

Name of the product:

mg/day for days

Directions:

Special instructions:

Titration directions, if needed:

Prescriber's signature required (NO STAMPS). I certify that therapy with the above-mentioned product is medically necessary for this patient and I have reviewed the current Prescribing Information for the prescribed product. I attest that I am not on the HHS/OIG List of Excluded Individuals and entities and that I am presently authorized under state law to prescribe and dispense the requested medication. I authorize and appoint the Foundation to convey on my behalf any prescription information delivered to the Foundation or to the dispensing pharmacy chosen by or for the patient. I am directing the pharmacy selected by the patient or the Foundation to dispense and/or administer the pharmaceutical product I have prescribed.

☐ Substitution permitted.

sign here ☐ Dispense as written. X / /

Prescriber's signature Date

I appoint the Otsuka Patient Assistance Foundation to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

Patient Assistance Foundation

Enrollment Form

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To be completed by the prescribing healthcare provider

SECTION 7. PRESCRIPTION INFORMATION (cont'd)

C. TREATING INJECTION PROVIDER (for injected product only)

To be filled out only if different from provider listed in section 6.

☐ SMHC ☐ MD office ☐ HOPD ☐ Unknown ☐ Other:

Expected discharge date (if applicable): ..... / /

Date of last injection: ..... / /

Date of next injection (if scheduled): ..... / /

Treating HCP name:

Treating site name:

Phone: ( ) - Fax: ( ) -

State license #:

TIN: NPI#:

Address:

City: State: Zip:

D. LIST OF INJECTION CENTER LOCATIONS (for injected product only)

Please send me a list of local care centers (LCCs).

☐ Closest to me ☐ Closest to my patient

☐ Please use the following approved LCC location

LCC name:

Address:

City: State: Zip:

E. HOSPITAL CONTACT (for injected product and hospital-administered product only)

Site name:

Contact name:

Preferred method of contact: ☐ Phone ☐ Fax ☐ Cell (text messaging)

Direct phone: ( ) - Fax: ( ) -

Alt. phone: ( ) - Alt. fax: ( ) -

Cell phone: ( ) -

Address:

City: State: Zip: