

Patient Assistance Foundation

Enrollment Form



The Otsuka Patient Assistance Foundation provides patients with prescribed Otsuka medication free of cost. Eligible patients can receive no-cost ABILIFY® (aripiprazole) Tablets, ABILIFY MAINTENA® (aripiprazole), SAMSCA® (tolvaptan), and REXULTI® (brexpiprazole).

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
- Include documentation that outlines the amount spent for prescription medicine in the relevant benefit year. Examples of documentation include: letter from plan provider, explanation of benefits (EOB), or clearly dated pharmacy printout showing amount paid for each medicine

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

There are two convenient ways to submit the completed form:

- Fax to 1-844-727-6274
- Mail to 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 (or the patient's) protected health information (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.

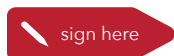
I acknowledge that my (or the patient's) household income and the number of people in my (or the patient's) household have been accurately reported on this form to the best of my ability and knowledge. In the event I am unable to provide financial documentation, I authorize the use of my Social Security 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



Signature of Patient or Legal Authorized Representative

____/____/____
Date



Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** for [ABILIFY](#), [ABILIFY MAINTENA](#), [SAMSCA](#), and [REXULTI](#).

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SECTION 2. PATIENT DEMOGRAPHIC INFORMATION

Check if copy of demographic/fact sheet is attached. You must still fill in your first name, last name, and DOB below.

First name: _____ Last name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ - _____ - _____ Gender: M F

DOB: ____ / ____ / ____ Preferred language: _____ Email: _____

Phone: (_____) _____ - _____ Mobile phone: (_____) _____ - _____

Check if there is a primary caregiver or an alternate contact.

Caregiver/alternate contact name: _____ Relationship: _____

Phone: (_____) _____ - _____ Mobile phone: (_____) _____ - _____

SECTION 3. PATIENT INSURANCE INFORMATION

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

I am attaching copies of all my insurance and prescription cards.

If you are not attaching copies of your insurance cards, please fill out the following section:

Medical Card

Payer name: _____ Plan name: _____

Phone: (_____) _____ - _____ Policyholder name: _____

Member ID: _____ Group #: _____ Policyholder DOB: ____ / ____ / ____

Prescription Card

Payer: _____ Member ID #: _____

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SECTION 4. INSURANCE ELIGIBILITY INFORMATION

- Do you have insurance or any prescription drug coverage?
(If YES, please attach copies of your insurance cards or 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 street address (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 before taxes*: \$ _____

Number of persons living in household, including yourself: _____

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

If you have Medicare Prescription Drug Coverage (Part D) and cannot afford your medication, you may be eligible for assistance. Please provide photocopy documentation showing what you have spent on prescription medicine for the relevant benefit year (letter from plan provider, explanation of benefits (EOB), or clearly dated pharmacy printout showing amount paid for each medicine).

*Includes salary/wages, Social Security income, unemployment insurance benefits, disability income, interest/dividends, and any other income for the household.

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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: _____

Provider's first and last name: _____

State license #: _____ Tax ID # _____ NPI #: _____

Site name: _____

Address: _____

City: _____ State: _____ Zip: _____

Provider's direct phone: (_____) _____ - _____ Ext: _____ Provider's fax: (_____) _____ - _____

Provider's email: _____

SECTION 7. PRESCRIPTION INFORMATION

Patient's name: _____ Patient's DOB: ____ / ____ / ____

Date of patient's admittance (if applicable): ____ / ____ / ____

Date of patient's discharge or expected discharge (if applicable): ____ / ____ / ____

ICD code: _____ Drug name: _____

A. DOSAGE

Check the box that applies and complete all applicable dosage information:

Oral tablets/Dosage (mg/day): _____ Days supply: 30 60 90 Number of refills _____

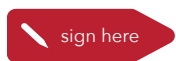
Injection/Dosage: _____ Quantity: _____ Dual-Chamber Syringe Vial Kit Number of refills _____

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.



Dispense as written.

Prescriber's Name

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.

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To be completed by the prescribing healthcare provider

SECTION 7. PRESCRIPTION INFORMATION (cont'd)

B. HOSPITAL CONTACT

Site name: _____

Contact's first and last name: _____

Preferred method of contact: Phone Fax Mobile (text messaging)

Direct phone: (_____) _____ - _____ Ext: _____ Fax: (_____) _____ - _____

Alternate phone: (_____) _____ - _____ Alternate fax: (_____) _____ - _____

Mobile phone: (_____) _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

C. TREATING INJECTION PROVIDER (for ABILIFY MAINTENA® [aripiprazole] only)

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

CMHC MD Office Hospital Outpatient Department Unknown

Other: _____

Date of last injection: ____ / ____ / ____ Date of next injection (if scheduled): ____ / ____ / ____

Treating healthcare provider name: _____

Treating site name: _____

Phone: (_____) _____ - _____ Ext: _____ Fax: (_____) _____ - _____

State license #: _____

Tax ID # _____ NPI #: _____

Address: _____

City: _____ State: _____ Zip: _____

D. LIST OF INJECTION CENTER LOCATIONS (for ABILIFY MAINTENA 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: _____

Abilify Maintena
(aripiprazole) for extended release injectable suspension

Please see FULL PRESCRIBING INFORMATION,
including **BOXED WARNING** for [ABILIFY MAINTENA](#).