ASSURE™

ASSURE ENROLLMENT FORM

The ASSURE Program™ has offerings to help support your patients' access to their prescribed treatment.

How to complete this enrollment form

Based on your patient's medication, there are only certain program offerings that apply:

1. Identify your patient's medication
2. Determine which program offering best fits your patient's needs
3. Refer to the chart of program offerings below to fill out the corresponding sections of the form

Check the program offerings that best fit your patient's needs:

☐ **Benefits Investigation**

Assistance with insurance coverage and prior authorizations. Patients prescribed ABILIFY MAINTENA® (aripiprazole) can also receive ASSURE Nurse Navigator support.

ABILIFY® (aripiprazole): ..... Sections 1-5
ABILIFY MAINTENA® (aripiprazole): ..... Sections 1-6
REXULTI® (brexpiprazole): ..... Sections 1-5
SAMSCA® (tolvaptan): ..... Sections 1-5, 7

☐ **Local Care Centers (Injection Centers) and Transition Support *Only* (for patients prescribed ABILIFY MAINTENA)**

Participating injection centers provide appointment coordination and medication administration

ABILIFY MAINTENA: ..... Sections 1, 2, 4-6

☐ **ASSURE Nurse Navigator *Only* (for patients prescribed ABILIFY MAINTENA)**

Nurse phone line offers appointment management and follow-up communications

ABILIFY MAINTENA: ..... Sections 1, 2, 4, 5

How to submit this enrollment form

There are two convenient ways to submit the completed form:

- **Fax to 1-855-876-2627**
- Mail to Otsuka America Pharmaceutical, Inc. ASSURE Program, PO Box 3640, Gaithersburg, MD 20885-3640

If you have any questions regarding the enrollment process or the information on this form, please visit ASSURE.com or call 1-855-242-7787, Monday – Friday, 8 AM – 8 PM ET.

ABILIFY® (aripiprazole) TABLETS

Abilify Maintena® (aripiprazole) for extended release injectable suspension

REXULTI® brexpiprazole tablets

Samsca® (tolvaptan)

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for ABILIFY, ABILIFY MAINTENA, REXULTI, and SAMSCA.

Otsuka Otsuka America Pharmaceutical, Inc.

 April 2018 ASUS18EXP0005

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TO BE COMPLETED BY THE PATIENT

1. PATIENT AUTHORIZATION

I (patient and/or caregiver) authorize that my (or the patient's) protected health information (PHI) may be sent to the ASSURE Program, disclosed to and reviewed by Otsuka and its authorized representatives and vendors, as described above, and disclosed to others by the ASSURE Program including:

- information provided on this form;
- my healthcare records related to my treatment and mental health condition(s);
- payer-related information received from my health insurer;
- prescription, fulfillment, shipment, information by pharmacies or other relevant sites of care; and
- hospitalization details and information to help support my transition of care.

I authorize that my PHI (or that of the patient) can be disclosed to and reviewed by employees and authorized agents, including vendors, of Otsuka working with the ASSURE Program including ASSURE Program call center staff, as necessary to provide the support available. This includes sending my PHI (or that of the patient) provided by my healthcare provider to my health insurers, pharmacies, advocacy organizations, third parties such as copay card vendors and the patient assistance program pharmacy. There is a potential for the information to be subject to re-disclosure by the recipient and no longer protected by HIPAA.

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 by the program in an effort to support continued access to prescribed treatment. Signing this consent form is voluntary. I understand that 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 ASSURE Program at 1-855-242-7787** or by sending a written notice to the ASSURE Program at PO Box 3640, Gaithersburg, MD 20885-3640. The withdrawal goes into effect once it has been received by the ASSURE Program. If you choose to not sign this authorization or you withdraw it after signing this form, the ASSURE Program will not be able to provide you with the support described above, after the date of your revocation.

OPTIONAL Communications by Otsuka

☐ I (patient and/or caregiver) am interested in receiving information, tools, and resources supporting my treatment from Otsuka. I understand I do not need to agree to this additional opt-in to be eligible to receive the Program services outlined above.

Email: _____

_____ _____

Patient Name or Legal Authorized Representative | Relationship to Patient

sign here

_____ ____ / ____ / ____

Signature of Patient or Legal Authorized Representative | Date

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TO BE COMPLETED BY THE PATIENT

2. PATIENT DEMOGRAPHIC INFORMATION

All fields are required, except those labeled *optional*.

First name: _____ Last name: _____ MI *(optional)*: _____

Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ - _____- _____ Gender: ☐ M ☐ F

DOB: ____ / ____ / ____ Preferred language *(optional)*: _____

Email *(optional)*: _____

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

Complete if there is a primary caregiver or an alternate contact:

Caregiver/alternate contact name: _____ Relationship: _____

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

3. PATIENT INSURANCE INFORMATION

All fields are required, except those labeled *optional*.

Check the box that applies:

☐ I do not have insurance.

☐ 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:

☐ My information is the same on both my medical card and prescription card.

If the information is the same between your medical and prescription cards, you only need to complete the Medical Card section below.

Medical Card

Payer name: _____ Plan name: _____

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

Member ID *(optional)*: _____ Group # *(optional)*: _____ Policyholder DOB *(optional)*: ____ / ____ / ____

Prescription Card

Member ID: _____ BIN: _____ PCN: _____

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TO BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROFESSIONAL

4. PRESCRIBER INFORMATION

All fields are required, except those labeled *optional*.

Specialty *(optional)*: ☐ Psychiatry ☐ Internal Medicine ☐ PA ☐ NP ☐ Nephrology ☐ Cardiology ☐ Oncology

☐ Other: _____

Site type *(optional)*: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ CMHC ☐ Local Care Center

☐ Other: _____

Name *(optional)*: _____ Contact's first and last name: _____

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

Site name *(optional)*: _____

Address: _____

City: _____ State: _____ ZIP: _____

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

Contact's email: _____

Check the box that applies:

If this is a **referral**, please complete **Section 6**.

☐ I am **referring** a patient. (You will only be notified about the patient's new site of care.)

☐ I am **referring** a patient and would like to continue to be informed of their treatment status.

☐ I am **receiving** this patient from another site of care.

5. PRESCRIPTION INFORMATION

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

ICD code: _____ Drug name: _____ Dosage: _____ Quantity: _____ Number of refills: _____

Directions: _____

☐ **Direct-to-Provider option:** I would like **the product shipped directly to my clinic** via a designated specialty pharmacy.
The ASSURE Program will contact you with additional information.

☐ I have a preferred specialty pharmacy.

Pharmacy: _____ Phone: (_____) _____ -_____

Address: _____

City: _____ State: _____ ZIP: _____

Prescriber's signature required (NO STAMPS). I certify that therapy with _____ is medically necessary for this patient, and I have reviewed the current Prescribing Information for the prescribed product. I appoint the ASSURE Program on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

sign here

☐ Dispense and administer.

☐ Dispense as written.

_____ ____ / ____ / ____

Prescriber's signature Date

I certify that the treatment listed above is, and will be, medically necessary based on my best professional judgment and that the information provided in this form is complete and accurate to the best of my knowledge and medical expertise. I also certify that I have obtained patient consent for the disclosure of protected health information (PHI) as required by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and any other legally required consents of the patient (or the patient's legal representative) for the release of the patient's information to the ASSURE Program (the "Program") and Otsuka or its representatives or agents, as may be necessary for the patient's participation in the Program, and for the Program and Otsuka to use and disclose such information as necessary to provide reimbursement support and other related information and resources to me and my patient in connection with the patient's therapy. I attest that I am not on the HHS/OIG list of Excluded Individuals and that I am presently authorized under State law to prescribe and dispense the requested medication. I authorize and appoint the Program and Otsuka to convey on my behalf any prescription information delivered to the Program to the dispensing pharmacy chosen by or for the patient. I understand that the Program and Otsuka will use and disclose this information only in connection with the Program, including but not limited to performing a benefit verification of the patient's insurance coverage for the prescribed treatment or triaging the patient's prescription to the patient's preferred pharmacy, as otherwise required or permitted by law.

I further certify that (a) any support provided through the Program on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use of any Otsuka product or service, and (b) my decision to prescribe the Otsuka product or service was based on my determination of medical necessity as set forth herein. I agree that the Program and Otsuka may contact me for additional information relating to the Program or Otsuka product, including but not limited to email, fax and telephone. I understand that Otsuka reserves the right, at any time and without notice, to modify or discontinue the Program. I understand that completing this enrollment form does not ensure that the patient will obtain insurance coverage or reimbursement for my prescription, and that any support provided through the Program are provided for informational purposes only and represent no statement, promise or guarantee by the Program or Otsuka. I agree that in no event shall Otsuka be liable for any damages resulting from or relating to the Program. I am directing the pharmacy selected by the patient or the Program to administer the pharmaceutical product I have indicated.

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TO BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROFESSIONAL

6. INJECTION CENTERS AND TRANSITION SUPPORT FOR ABILIFY MAINTENA® (aripiprazole)

Please provide the following information to facilitate the transition:

Date of patient's discharge: ____ / ____ /____ Date of last injection: ____ / ____ / ____

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

☐ I will be **referring** this patient to the site of care listed below:

☐ CMHC ☐ MD Office ☐ Hospital Outpatient Department

☐ Local Care Centers (injection centers) ☐ Other

Receiving HCP name: _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

Receiving site name: _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

ASSURE Local Care Center (injection center):

_____

Address: _____

City: _____ State: ____ ZIP: _____

☐ I need **assistance** finding a site of care that can administer ABILIFY MAINTENA.

ASSURE can provide a list of Local Care Centers (injection centers) based on the patient's preferred location.

☐ Home ☐ MD Office ☐ Other

Address: _____

City: _____ State: ____ ZIP: _____

7. PHARMACY INFORMATION FOR SAMSCA® (tolvaptan)

Please provide the following information to assist the pharmacy:

Anticipated treatment date: ____ / ____ / ____ Total quantity dispensed since hospital admission: _____

Expected discharge date: ____ / ____ / ____

Has the prescription been sent to a preferred pharmacy? ☐ Yes ☐ No

If yes, pharmacy name: _____

If not, check the preferred pharmacy below and provide specific phone and address if known:

☐ Accredo ☐ Cigna Specialty Pharmacy ☐ Walgreens Specialty Pharmacy ☐ BriovaRx

☐ CVS Specialty Pharmacy ☐ Safeway Specialty Pharmacy

Regional Specialty Pharmacy:

☐ 15Rx ☐ DirectRx ☐ Premier Pharmacy Services

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

Address: _____

City: _____ State: _____ ZIP: _____

ASSURE will make the best attempt to honor the pharmacy selected above.

Please note that the payer may dictate a different preferred specialty pharmacy.

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for ABILIFY MAINTENA and SAMSCA.

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