

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 MAINTENA® (aripiprazole): Sections 1-5, 7

REXULTI® (brexpiprazole): Sections 1-4, 7

SAMSCA® (tolvaptan): Sections 1-4, 6, 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, 3-5, 7

ASSURE Nurse Navigator Only (for patients prescribed ABILIFY MAINTENA)

Nurse phone line offers appointment management and follow-up communications

ABILIFY MAINTENA: Sections 1, 3, 4, 7

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 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 MAINTENA](#), [REXULTI](#), and [SAMSCA](#).

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TO BE COMPLETED BY THE PATIENT

1. 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: (_____) _____ - _____

2. 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

3. 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: _____ Contact's first and last name: _____

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

Site name: _____

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.

4. 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.

 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

5. 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): ___ / ___ / ___

<input type="checkbox"/> I will be referring this patient to the site of care listed below: <input type="checkbox"/> CMHC <input type="checkbox"/> MD Office <input type="checkbox"/> Hospital Outpatient Department <input type="checkbox"/> Local Care Centers (injection centers) <input type="checkbox"/> Other Receiving HCP name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____ Receiving site name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____ ASSURE Local Care Center (injection center): _____ Address: _____ City: _____ State: ____ ZIP: _____	<input type="checkbox"/> 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. <input type="checkbox"/> Home <input type="checkbox"/> MD Office <input type="checkbox"/> Other Address: _____ City: _____ State: ____ ZIP: _____
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6. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, pharmacy name: _____ If not, check the preferred pharmacy below and provide specific phone and address if known: <input type="checkbox"/> Accredo <input type="checkbox"/> Cigna Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy <input type="checkbox"/> BriovaRx <input type="checkbox"/> CVS Specialty Pharmacy <input type="checkbox"/> Safeway Specialty Pharmacy Regional Specialty Pharmacy: <input type="checkbox"/> 15Rx <input type="checkbox"/> DirectRx <input type="checkbox"/> 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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TO BE COMPLETED BY THE PATIENT

7. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize that my protected health information (PHI) may be sent to the ASSURE Program, disclosed to and reviewed by Otsuka and its authorized representatives and vendors 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 may be disclosed by my healthcare provider, including my ASSURE Local Care Center provider(s), my health insurer and my pharmacy; to employees and authorized agents, ASSURE call center staff, and vendors of Otsuka working with the ASSURE Program, as is necessary to provide the available support. The support offered by the ASSURE Program may include: providing information on plan benefits, benefits verifications, prior authorizations, and sending refill reminders. The ASSURE Program is permitted to send my PHI to my health insurers, my healthcare providers, my pharmacies, and third parties such as copay card vendors to provide support to me. In addition, my PHI will be used and disclosed for purposes of sending me information, tools, and resources related to my treatment with Otsuka's products or as required by law. My PHI may be used for analyzing and improving the ASSURE Program.

I understand that my ASSURE Local Care Center(s) may receive payment for data associated with my PHI that they disclose to Otsuka and its authorized vendors.

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 one (1) year 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. Additionally, my ability to enroll in a health plan, my eligibility for benefits and payment for services by my health insurer will not be affected if I do not sign this form.

I understand that I may revoke (i.e. take back) this authorization at any time, except to the extent my healthcare provider or insurer has taken action in reliance on my authorization. I may revoke 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 revocation goes into effect once it has been received by the ASSURE Program. I understand that if I revoke, it will not have any effect on any uses or disclosures of my PHI that occurred prior to receiving my revocation. I understand that if I choose to not sign this authorization or I revoke it after signing it, the ASSURE Program will not be able to provide me with the support described above, after the date of my revocation.

Patient Name or Legal Authorized Representative

Relationship to Patient



Signature of Patient or Legal Authorized Representative

____ / ____ / ____
Date

If signed by the Patient's Legal Representative, provide a description of your relationship to the patient, your authority to act for the patient, and furnish a copy of the healthcare power of attorney or other relevant document authorizing you as the representative.