ASSURE™

ASSURE ENROLLMENT FORM

The ASSURE Program™ is dedicated to your patients throughout their treatment journey.

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

Benefits Investigation

Assistance with insurance coverage and prior authorizations plus ASSURE Navigator support

ABILIFY® (aripiprazole): ..... Sections 1-7
ABILIFY MAINTENA® (aripiprazole): ..... Sections 1-8
REXULTI® (brexpiprazole): ..... Sections 1-7
SAMSCA® (tolvaptan): ..... Sections 1-7, 9

ASSURE Navigator Only

Nurse phone line offers appointment management and follow-up communications

ABILIFY MAINTENA: ..... Sections 1,2,5,7
REXULTI: ..... Sections 1,2,5,7

Local Care Centers (Injection Centers) and Transition Support Only

Participating injection centers provide appointment coordination and medication administration

ABILIFY MAINTENA: ..... Sections 1,2,5,6,7,8

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 220684, Charlotte, NC 28222-0684

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 8AM – 8PM ET

ABILIFY® (aripiprazole) TABLETS

Abilify Maintena® (aripiprazole) for extended release injectable suspension

Samsca® (tolvaptan)

REXULTI® brexpiprazole tablets

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

Otsuka Otsuka America Pharmaceutical, Inc.

 March 2017 ASUS17EBP0022

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TO BE COMPLETED BY THE PATIENT

1. PATIENT AUTHORIZATION

I (patient and/or caregiver) authorize that my PHI (or the patient's 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 220684, Charlotte, NC 28222-0684. 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.

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

sign here

Signature of Patient or Legal Authorized Representative	Date
	/ /

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TO BE COMPLETED BY THE PATIENT

2. PATIENT DEMOGRAPHIC INFORMATION

First name: Last name: MI:

Address:

City: State: Zip:

SSN: - - Gender: M F

DOB: / / Preferred language: Email:

Phone: ( ) - Cell phone: ( ) -

Check if a caregiver is the primary contact

Caregiver name: Relationship:

Phone: ( ) - Cell phone: ( ) -

3. PATIENT INSURANCE INFORMATION

I do not have insurance.

I have insurance coverage for prescription medications. Please attach copies of all insurance and prescription cards OR fill out the following section.

Medical Card

Payer name: Plan name:

Phone: ( ) - Policyholder name:

Member ID: Group #: Policyholder DOB: / /

Prescription Card

Member ID: BIN: PCN:

4. PATIENT PREFERRED PHARMACY

Pharmacy name: Contact name:

Phone: ( ) - Fax ( ) -

Address:

City: State: Zip:

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TO BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROFESSIONAL

5. PRESCRIBER INFORMATION

Specialty: ☐ Psychiatry ☐ Internal medicine ☐ PA ☐ NP ☐ Nephrology ☐ Cardiology ☐ Oncology

☐ Other:

Name: Contact name:

State license #: TIN: NPI#:

Site name:

Address:

City: State: Zip:

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

Contact email:

Check the box that applies:

☐ I am **referring** this patient to another site of care. If this is a **referral**, please complete **Section 8**.

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

6. DIAGNOSIS

ICD code: Description:

7. PRESCRIPTION INFORMATION

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

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

Directions:

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

☐ Substitution permitted.

☐ 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

8. 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 ☐ HOPD

☐ Local Care Centers (injection centers) ☐ Other

Receiving HCP name:

Receiving site name:

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:

9. 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 prescription been sent to preferred pharmacy? ☐ Yes ☐ No

If yes, pharmacy name:

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

☐ Accredo ☐ Cigna Specialty Pharmacy ☐ K-Mart Specialty Pharmacy ☐ Walgreens Specialty Pharmacy ☐ BriovaRx

☐ CVS Specialty Pharmacy ☐ Safeway Specialty Pharmacy

Regional Specialty Pharmacy

☐ 15Rx ☐ DirectRx ☐ Premier Pharmacy Services

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

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

Phone: ( ) - Fax: ( ) -

Address:

City: State: Zip:

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

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