OTSUKA PATIENT ASSISTANCE FOUNDATION, INC.
PO Box 4530, Chesterfield, MO 63006
PHONE: 1-855-727-6274 FAX: 1-844-727-6274

Otsuka | PATIENT ASSISTANCE FOUNDATION

SAMSCA® (tolvaptan) RE-INITIATION OF THERAPY

Today's Date: (mm/dd/yyyy): _____

I, _____, attest the patient, _____,

date of birth, _____ , re-initiated therapy in the hospital for SAMSCA® (tolvaptan) tablets. The patient was accepted into the Otsuka Patient Assistance Foundation Inc. (OPAF) within the last 12 months and would like to re-apply for assistance.

PRESCRIBER INFORMATION:

Prescriber Name: _____

State License #: _____ NPI#: _____

Direct Contact's Name: _____

Site Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Contact Direct Phone: _____ Ext: _____ Contact Fax: _____

Contact Email: _____

PATIENT INFORMATION:

First Name: _____ Last Name:_____ MI: _____

DOB (mm/dd/yyyy): _____ ICD-10 Code: _____

Patient Address: _____ City: _____ State: _____ ZIP: _____

Patient Cell Number: _____ Patient Email: _____

PRESCRIPTION INFORMATION:

Diagnosis: _____

Dose of SAMSCA: (Check one) ☐ 30mg ☐ 15mg (Check one) ☐ QD ☐ BID

Quantity: _____(SAMSCA is indicated for no more than 30 Days Supply)

Date of Hospital Admission (mm/dd/yyyy): _____Date of Hospital discharge or expected discharge (mm/dd/yyyy): _____

Dosage while in Hospital: (Check one) ☐ 30mg ☐ 15mg Dosing frequency: _____

Number of SAMSCA tablets administered during hospital stay: _____

Number of SAMSCA tablets dispensed at hospital discharge: _____

I appoint the Otsuka Patient Assistance Foundation (hereafter, referred to as OPAF) to convey this prescription to the dispensing pharmacy. 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 this medication. I authorize and appoint OPAF to convey on my behalf any prescription information delivered to the dispensing pharmacy. For the purposes of transmitting this prescription, I authorize OPAF and its affiliates as my agent for these limited purposes to forward this prescription electronically, or via fax, or via mail to the dispensing pharmacy. I certify that any medication received will be used only for the patient named on this application and will not be offered for sale, trade, or barter. I acknowledge that OPAF is a free goods, non-profit program that assists patients that have been approved for assistance by meeting specific criteria. I acknowledge, that at any time, I can change or withdraw this prescription on the patient's behalf due to the medical needs of the patient by calling 1-855-727-6274 or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation Inc., PO Box 4530, Chesterfield, MO 63006. I understand that OPAF may revise, change, or terminate programs at any time.

☐ **Dispense as written**

Prescriber's Name: _____

Sign here _____ **Date:** (mm/dd/yyyy) _____

Samsca® (tolvaptan)

Please see FULL PRESCRIBING INFORMATION including BOXED WARNING and MEDICATION GUIDE for SAMSCA® (tolvaptan) tablets at www.samsca.com .

 Confidential-Protected Health Information August 2023 PAUS23EBB0013