We are here to help! Call the Otsuka Patient Assistance Foundation Inc., (OPAF) to speak with a dedicated Patient Access Advocate at 1-855-727-6274

Otsuka PATIENT ASSISTANCE FOUNDATION

HOW TO APPLY FOR OTSUKA PATIENT ASSISTANCE

To expedite the application process, healthcare professionals and patients may fill out and submit an application with all requested documentation online via the OPAF Care Connect portal at www.otsukapatientassistance.com. Alternatively, the completed paper application including all requested documentation may be submitted via fax at 1-844-727-6274, secure messaging or by postal mailing the application to Otsuka Patient Assistance Foundation, Inc., PO Box 501878, San Diego, CA 92150-1878. Eligibility determination may take up to 3 business days upon receipt of the application and all requested documentation.

NOTE: Receipt of incomplete applications can lead to delays in processing.

PATIENTS OR LEGAL AUTHORIZED REPRESENTATIVE

IMPORTANT: ✓ Please read and sign the patient authorization page 2
✓ Please fill out Section 1 through Section 3

Proof of your household gross income is REQUIRED. You can choose ONE of the following options to verify your proof of income per household income earner. Please submit this documentation with the application.

- ☐ Federal Income Tax Return (1040, etc)
- ☐ W-2 from previous tax year
- ☐ 1099-MISC Form
- ☐ 2 most recent paystubs
- ☐ Income attestation letter from provider
- ☐ Social Security award letter
- ☐ Disability income information
- ☐ Unemployment benefits letter
- ☐ Letter from employer on company letterhead

Eligibility is not determined by US citizenship. However, a US home address is REQUIRED. Applicant must include proof of US address with the application submission. Please submit ONE of the following:

- ☐ Mortgage statement or Rental agreement
- ☐ Two (2) utility bills
- ☐ State Driver's License or State ID (with current home address)
- ☐ US Address attestation letter from provider
- ☐ Attestation letter from residential facility (if applicant is transient)

HEALTHCARE PROVIDERS

IMPORTANT: ✓ Please complete Section 4 through Section 7 including prescription with Prescriber's signature
✓ Please submit prescriptions by eScript if mandated by individual state laws. The prescriber must comply with state laws regarding e-prescribing, state-specific prescription form, or written prescription.

HOW TO SUBMIT THE FORM AND DOCUMENTATION

Submitting your application has never been easier! You can apply online through the OPAF Care Connect Portal OR fill out this paper application and submit via fax or postal mail.

OPTION 1 - Access the OPAF Care Connect Portal via www.otsukapatientassistance.com

OPTION 2 - Fax paper application to **1-844-727-6274**

OPTION 3 - Mail paper application to: **Otsuka Patient Assistance Foundation, Inc.**
PO Box 501878,
San Diego, CA 92150-1878

OTSUKA PATIENT ASSISTANCE FOUNDATION, INC
PATIENT AUTHORIZATION, AGREEMENT AND CONSENT

To be completed by the patient or the patient's legal representative:
Patient authorization for use and disclosure of health information and financial information for financial assistance application, review, and determination.

I authorize that my personally identifiable health information ("Personal Health Information"), can be sent by my healthcare providers, pharmacies, health insurers, and healthcare plans, to Otsuka Patient Assistance Foundation, Inc. (hereafter referred to as OPAF). OPAF may in turn share my Personal Health Information with my healthcare providers, pharmacies, health insurer(s), individuals that I have identified as my caregivers, and other OPAF third-party contractors or service providers, for the sole purpose of reviewing my application information and making an application determination. In addition, OPAF may remove all direct and indirect identifiers from my Personal Health Information to create anonymized data that cannot be used to identify me. OPAF may use my anonymized data for internal data collection, including but not limited to record keeping, reporting of national insurance coverage trends, cost-share and tracking of payer trends. OPAF, its designated third party authorized representatives, my healthcare professionals, pharmacies, health insurer(s), OPAF's third party contractors, and OPAF's service providers may utilize the information listed below for application determination and internal data collection as described above:

- information provided on this form;
- my healthcare records related to my treatment;
- payer-related information received from my health insurer;
- prescription and/or prescription status from pharmacies or other relevant sites of care; and
- hospitalization details and information to help support my transition of care.

FINANCIAL INFORMATION AND FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION

I acknowledge that OPAF will utilize my household income and the number of people in my household listed on my application for determination of eligibility. I attest that I have been accurately reported on this application 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. I understand that I am providing "written instructions" authorizing OPAF and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for eligibility determination by OPAF. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

PATIENT (OR LEGAL REPRESENTATIVE) CONSENT

This consent will remain in effect for (1) one year from the date of my signature. I understand that I may be requested to provide my written consent on an annual basis if I require continued assistance from OPAF. 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. 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 consent at any time, however any use or disclosure of my Personal Health Information that occurred prior to my revocation will not be affected. After I have signed this consent, I may revoke it by calling OPAF at 1-855-727-6274 or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation Inc., PO Box 501878, San Diego, CA 92150-1878. If I choose not to sign this consent or I revoke it after signing this form, I understand that OPAF will no longer be able to provide support after the date of my revocation.

By signing this consent, I agree to the terms listed above. I also consent to receiving communications from OPAF regarding my enrollment with OPAF and other program updates via secure or text messages. I understand that I can opt-out of receiving these communications at any time by following the opt-out instructions within the secure or text message. I acknowledge that my carrier may apply additional data rate charges per text message that is received, and that OPAF is not responsible for the costs incurred.

Patient First Name:_____ Patient Last Name:_____ Patient Date of Birth (mm/dd/yyyy):_____

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

Or, if this form is submitted by the patient's legal representative:

Legal Representative First Name: _____ Last Name: _____

**Legal Representative Signature: _____ Today's Date (mm/dd/yyyy): _____

**If a legal representative is signing on behalf of a patient, power of attorney documentation is required with the application submission.

OTSUKA PATIENT ASSISTANCE FOUNDATION APPLICATION FORM

SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Gender: ☐ Male ☐ Female Patient SSN: _____ Patient Date of Birth (mm/dd/yyyy): _____

Patient Cell Number: _____ Patient Alternate Contact Number: _____

Patient Email: _____

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

Caregiver/Parent/Legal Guardian/Alternate Contact: First Name: _____ Last Name: _____

Relationship to Patient: _____ Contact Number: _____

SECTION 2: INSURANCE INFORMATION

PLEASE CHECK ONE OF THE FOLLOWING OR FILL OUT THE MEDICAL & PHARMACY INSURANCE INFORMATION BELOW.

☐ I DO NOT have insurance (do not fill out Section 2) ☐ I am attaching a copy of pharmacy card (do not fill out Section 2)

MEDICAL CARD: Payer Name: _____ Plan Name: _____

Policyholder Name: _____ Phone: _____

Member ID: _____ Group #: _____ Date of Birth (mm/dd/yyyy): _____

PHARMACY CARD: Payer Name: _____

Plan Name: _____ Phone: _____

RxBIN: _____ RX PCN: _____

SECTION 3: FINANCIAL AND RESIDENCY ELIGIBILITY

PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY. DOCUMENTATION IS REQUIRED WITH THIS SECTION TO AVOID PROCESSING DELAYS.

Annual household income $_____(Include all income earners contributing within the home)

Number of people in household (including yourself):_____

Proof of your household gross income is REQUIRED. You can choose ONE of the following options to verify your proof of income per household income earner. Please submit this documentation with the application.

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Eligibility is not determined by US citizenship. However, a US home address is REQUIRED. Applicant must include proof of US address with the application submission. Please submit ONE of the following:

- ☐ Mortgage statement or Rental agreement
- ☐ Two (2) utility bills
- ☐ State Driver's License or State ID (with current home address) ☐ US Address attestation letter from provider
- ☐ Attestation letter from residential facility (if applicant is transient)

OTSUKA PATIENT ASSISTANCE FOUNDATION APPLICATION FORM (CONT'D)

SECTION 4: PRESCRIBER INFORMATION

First Name: _____ Last Name: _____

State License #: _____ Tax ID #: _____

DEA #: _____ NPI #: _____

Facility Name: _____ Facility Phone Number: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

PRIMARY CONTACT: Direct Contact's First Name: _____ Last Name: _____

Contact's Direct Phone: _____ Ext: _____ Contact's Fax: _____

Contact's Email: _____

SECTION 5: ABILIFY ASIMTUFII® (ARIPIPRAZOLE) PRESCRIPTION INFORMATION

PLEASE SUBMIT PRESCRIPTIONS BY ESCRIPT IF MANDATED BY INDIVIDUAL STATE LAWS. THE PRESCRIBER MUST COMPLY WITH STATE LAWS REGARDING E-PRESCRIBING, STATE-SPECIFIC PRESCRIPTION FORM, OR WRITTEN PRESCRIPTION.

Patient First Name: _____ Patient Last Name: _____

Patient Date of Birth (mm/dd/yyyy): _____ Patient ICD-10 code: _____

If approved for assistance, will this be the patient's first administration of ABILIFY ASIMTUFII® (aripiprazole)? ☐ Yes ☐ No

ABILIFY ASIMTUFII® (aripiprazole): (Check one) ☐ 720 mg dosed every 2 months ☐ 960 mg dosed every 2 months

Dispense: Dual-Chamber Syringe ONLY

Route of Administration: Intramuscular injection in the gluteal muscle ONLY by a healthcare professional

Date of Next Injection: _____ Number of Refills: _____

SHIP TO: (Check one)

☐ Prescriber Facility
☐ My patient needs their injection administered at an alternative facility called a Local Care Center (LCC). Please assist my patient in finding an LLC.
☐ Please send my patient's injection to the indicated alternative injection facility called a Local Care Center (LCC) for administration.

Local Care Center Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

I appoint the Otsuka Patient Assistance Foundation, Inc. (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 501878, San Diego, CA 92150-1878. I understand that OPAF may revise, change, or terminate programs at any time.

☐ **Dispense as written**

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

Abilify Asimtufii® (aripiprazole) extended release suspension for injection

Please see FULL PRESCRIBING INFORMATION, including BOXED WARNING and MEDICATION GUIDE at www.abilifyasimtufiihcp.com

OTSUKA PATIENT ASSISTANCE FOUNDATION APPLICATION FORM (CONT'D)

Patient First Name: _____ Patient Last Name: _____

Patient Date of Birth (mm/dd/yyyy):_____

SECTION 6: VITAMIN PRESCRIPTION

ENROLLED PATIENTS HAVE THE OPTION TO RECEIVE SELECT NATURE MADE® VITAMINS, FOR FREE FROM OPAF. PLEASE INDICATE BELOW WHAT VITAMINS YOU WOULD LIKE THE PATIENT TO RECEIVE.

☐	Biotin 2500 mcg	*Take one capsule daily*	Qty:	90	Refills: _____
☐	*Calcium 600 mg	*Take one softgel daily*	Qty:	100	Refills: _____
☐	Omega 1200 mg	*Take one capsule daily*	Qty:	100	Refills: _____
☐	Folic Acid 400 mcg	*Take one tablet daily*	Qty:	250	Refills: _____
☐	Iron 65mg (325 Ferrous Sulfate)	*Take one tablet daily*	Qty:	180	Refills: _____
☐	Multi-Vitamin (Multi Complete)	*Take one tablet daily*	Qty:	130	Refills: _____
☐	Super B - Complex	*Take one tablet daily*	Qty:	140	Refills: _____
☐	Vitamin A 2400 mcg (8000 IU)	*Take one capsule daily*	Qty:	100	Refills: _____
☐	Vitamin B1 100 mg	*Take one tablet daily*	Qty:	100	Refills: _____
☐	Vitamin B6 100 mg	*Take one tablet daily*	Qty:	100	Refills: _____
☐	Vitamin B12 1000 mcg	*Take one capsule daily*	Qty:	90	Refills: _____
☐	Vitamin C 1000 mcg (Chewable)	*Take one tablet daily*	Qty:	90	Refills: _____
☐	Vitamin C 1000 mg	*Take one tablet daily*	Qty:	100	Refills: _____
☐	Vitamin D 50 mcg (2000 IU)	*Take one tablet daily*	Qty:	100	Refills: _____
☐	Vitamin E 180 mg (400 IU)	*Take one capsule daily*	Qty:	100	Refills: _____

*Calcium 600 mg or 500 mg, depending on availability

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☐ Dispense as written

Prescriber's Name: _____

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