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 4530, Chesterfield, MO 63006. 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.

Patient or Legal Representative

Your forms have blue headers.

- ❑ **Patient Authorization** (Please read and sign page 2)
- ❑ **Patient Information** (Please complete page 3, section 1, 2, and 3)
- ❑ **Proof of Household Gross Income**
  Proof of your household gross income is **REQUIRED**. Please submit **ONE** of the following options to verify your proof of income per contributing 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
- ❑ **Proof of U.S. Address**
  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

Your forms have red headers.

- ❑ **Please complete Section 4 through Section 6 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 4530,
Chesterfield, MO 63006

NEED MORE HELP? VIEW OUR "HOW TO APPLY" VIDEO →

Or Call 1-855-727-6274 Monday - Friday 8am-6pm

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. When my information is redisclosed, it may not be covered by the Health Insurance Portability and Accountability Act (HIPAA), which my providers, pharmacies and insurers (for example) must follow. However, if there are additional state requirements, those shall be followed where applicable. 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.

OPAF privacy policy governs the use of the information you provide and your rights regarding your data and can be found at https://www.otsukapatientassistance.com/privacy-policy

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. The revocation goes into effect once it has been received and will not affect the information that had been sent or obtained prior to the date of revocation. 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 4530, Chesterfield, MO 63006. 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.

PATIENT (OR LEGAL REPRESENTATIVE) COMMUNICATION CONSENT

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 electronic secure message or text messages. By consenting to text messages, I understand that although every effort is made to protect information, SMS/text messages may not be secure. I understand that my consent is not required or a condition of this program. I understand that I can opt-out of receiving these communications at any time by following the opt-out instructions within the electronic secure message 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. For additional information, see our privacy policy at https://www.otsukapatientassistance.com/privacy-policy. I consent to receive text messages the cell phone number below.

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

*Cell Phone Number utilized for consenting texting: _____

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

*Legal Representative First Name: _____ *Last Name: _____

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

***REQUIRED FIELD MUST BE FILLED OUT**

OTSUKA PATIENT ASSISTANCE FOUNDATION APPLICATION FORM

SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Gender: ☐ M ☐ F ☐ Other ☐ Decline to Specify Patient SSN: _____ Patient Date of Birth (mm/dd/yyyy): _____

Patient Cell Number: _____ Patient Alternate Contact Number: _____

Patient Email: _____

Preferred Method of Contact for Our Determination: ☐ Postal Mail ☐ Secure 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 insurance 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: _____

Member ID: _____ RxGroup: _____

RxBIN: _____ RX PCN: _____

Have you applied for Medicare Low Income Subsidy? ☐ Yes ☐ No

Have you applied for Medicaid? ☐ Yes ☐ No

If insured commercially, has a prior authorization been submitted? ☐ Yes ☐ No

If YES, has a determination been made? ☐ Yes ☐ No

SECTION 3: FINANCIAL AND RESIDENCY ELIGIBILITY

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

Gross income is required for all household members that contribute income to the household. Please provide the number of household members in your home, including yourself, spouse/partner, and dependents: _____

Annual household income for all contributing members of household. $_____

PLEASE NOTE. Proof of your household gross income is REQUIRED. Please choose ONE approved document per household income earner to verify their income and submit this documentation with the application. See PAGE 1 for a list of approved documents to include.

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. See PAGE 1 for a list of approved documents and submit ONE with the application.

OTSUKA PATIENT ASSISTANCE FOUNDATION APPLICATION FORM (CONT'D)

SECTION 4: PRESCRIBER INFORMATION

First Name: _____ Last Name: _____

State License #: _____ NPI #: _____

Facility Name: _____ Facility Phone #: _____ Fax #: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

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

Contact's Direct Phone: _____ Ext: _____

Contact's Email: _____

SECTION 5: VOYXACT® (sibeprenlimab-szsi) 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.

☐ Check here if you will be E-Prescribing

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

Patient First Name: _____ Patient Last Name: _____

If approved for assistance, will this be the patient's first administration of VOYXACT® (sibeprenlimab-szsi)? ☐ Yes ☐ No

If NO, when was the date of patient's first medication dose? _____

VOYXACT® (sibeprenlimab-szsi): Dosage: ☐ 400mg subcutaneously every 4 weeks

Quantity: 12-Week Supply

Alternative Directions: _____

Number of Refills: _____

☐ Check here if your patient needs a sharps container for safe needle disposal.

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): _____

Voyxact®
(sibeprenlimab-szsi)
Injection 400 mg/2 mL

Please see FULL PRESCRIBING INFORMATION and PATIENT INFORMATION at www.voyxact.com

OTSUKA PATIENT ASSISTANCE FOUNDATION APPLICATION FORM (CONT'D)

Patient First Name: _____ Patient Last Name: _____

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

SECTION 6: OPAF RESOURCE & SOLUTIONS CENTER

If approved, you may also opt in for the OPAF Resource & Solutions Center which includes access to additional offerings.

☐ Check here, if you would you like someone to reach out to you about OPAF Resource & Solutions Center offerings.

☐ Check here, to opt in to receive our free Health & Wellness Kit.

☐ Check here, if you are interested in receiving select free NatureMade® vitamins, pending acceptance from OPAF and approval of your health care provider.

OPTIONAL SURVEY QUESTIONS

Please answer the following questions to help us serve you better.

1. Ultimately, I bear the responsibility for maintaining my [mental] well-being.
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree
2. Being proactive in managing my well-being significantly impacts both my health and overall functioning.
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree
3. I am confident in my level of comfort to proactively address challenges and identify solutions with my health professional.
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree
4. I have confidence that I can carry out health treatment plans that I may need to follow at home.
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree
5. I am confident that I can sustain lifestyle changes, such as maintaining a healthy diet and regular exercise, even during stressful periods.
   ☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree