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

NEW PROVIDER ATTESTATION FORM (PAGE 1)
FOR VOYXACT® (sibeprenlimab-szsi)

PRESCRIPTION INFORMATION & SIGNATURES ARE REQUIRED ON PAGE 2 FOR CONTINUATION OF ENROLLMENT

I, _____ , attest that I am the new prescribing provider for, _____, date of birth, _____ . It is believed that this patient is actively enrolled in the Otsuka Patient Assistance Foundation, Inc (OPAF). Below I am providing my provider information and a new prescription, please update the patient's case record.

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: _____

PLEASE NOTE: MISSING OR INCOMPLETE INFORMATION COULD DELAY PROCESSING

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: _____

PRESCRIPTION INFORMATION & SIGNATURES ARE REQUIRED ON PAGE 2
FOR CONTINUATION OF ENROLLMENT

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

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

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NEW PROVIDER ATTESTATION FORM (PAGE 2)
FOR VOYXACT® (sibeprenlimab-szsi)

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): _____

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(sibeprenlimab-szsi)
Injection 400 mg/2 mL

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