HOW TO APPLY TO OTSUKA PATIENT ASSISTANCE

To expedite the application process, healthcare professionals may fill out and submit an application with all requested documentation online via the OPAF Care Connect portal at www.otsukapatientassistance.com. Eligibility determination may take up to 48 hours upon submission of the application and all requested documentation.

OR

Healthcare professionals may submit a completed paper application including all requested documentation via fax at 1-844-727-6274 or by mailing the application to Otsuka Patient Assistance Foundation, Inc., PO Box 3640, Gaithersburg, MD 20885-3640. Eligibility determination may take up to 5 business days upon receipt of this application and all requested documentation.

PATIENTS OR LEGAL AUTHORIZED REPRESENTATIVE

- Read and sign the patient authorization page 2
- Fill out page 3

Applicant must include proof of income for all contributing members of the household with the application submission. Please submit ONE of the following for each contributing members:

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

Applicant must include proof of residency with the application submission. Please submit ONE of the following:

- Social Security number
- State driver's license
- US birth certificate
- US passport
- Foreign passport with US visa
- I-94 form with photograph
- US military ID
- US certificate of naturalization or citizenship

HEALTHCARE PROVIDERS

- Complete page 4 including prescription with Prescriber's signature
- NY, NJ, IA physicians must supply a prescription per state regulations

HOW TO SUBMIT THE FORM AND DOCUMENTATION

- Go to www.otsukapatientassistance.com and apply online via the Care Connect Portal
- Fax paper application to 1-844-727-6274
- Mail paper application to Otsuka Patient Assistance Foundation, Inc., PO Box 3640, Gaithersburg, MD 20885-3640

OTSUKA PATIENT ASSISTANCE FOUNDATION CONSENT LANGUAGE

To be completed by the patient or legal authorized representative: patient authorization for use and disclosure of health information and financial information for application determination

PATIENT AGREEMENT & CONSENT

I authorize that my personal health information can be sent to Otsuka Patient Assistance Foundation, Inc. (hereafter referred to as OPAF). I give permission for OPAF to disclose my personal health information (hereafter, referred to as PHI) to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the sole purpose of reviewing my application information and application determination. In addition, OPAF may use my de-identified PHI for internal data collection, reporting of national insurance coverage trends, cost-share and payer trends for OPAF operational purposes. OPAF, designated third party authorized representatives, healthcare professionals, pharmacies, health insurer(s), third party contractors, and service providers will 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 and mental health condition(s);
- 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

By signing this consent, I agree to the terms listed above. Applicant's PHI and financial authorization and notice of release 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 in an effort to support continued access to my medication. 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 authorization at any time, except to the extent my healthcare provider or insurer has taken action in reliance on my authorization. After I have signed this consent, I may withdraw 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 3640, Gaithersburg, MD 20885-3640. If I choose not to sign this authorization or I withdraw it after signing this form, I understand that OPAF will no longer be able to provide support after the date of my revocation.

Patient first and last name:_____ Date of birth (mm/dd/yyyy):_____

Patient signature:_____ Date (mm/dd/yyyy): _____

Legal representative first and last name:_____

Legal representative signature:_____ Date (mm/dd/yyyy): _____

**When legal representative is signing on behalf of a patient, please include legal representative documentation with this application.

OTSUKA PATIENT ASSISTANCE PROGRAM APPLICATION FORM

SECTION 1: PATIENT INFORMATION

First name

Last name

Address

City | State | Zip

Gender | SSN | DOB (mm/dd/yyyy)

☐ M ☐ F

Phone

Email

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

Caregiver/alternate contact name

Relationship | Phone

SECTION 2: INSURANCE INFORMATION

☐ **I DO NOT have insurance (do not fill out Section 2)**

☐ **I am attaching copies of both medical and pharmacy cards (do not fill out Section 2)**

MEDICAL CARD

Payer name | Plan name

Phone | Policyholder name

Member ID | Group # | DOB (mm/dd/yyyy)

PHARMACY CARD

Payer name | Plan name

Phone

RxBIN | RX PCN

SECTION 3: INSURANCE ELIGIBILITY

Have you been denied coverage by an insurance provider?

☐ Yes ☐ No

Are you enrolled in Medicare, Medicaid, Veterans Affairs, or TRICARE?

☐ Yes ☐ No

Have you been denied Medicaid?

☐ Yes ☐ No

Are you in the process of enrolling in Medicare Part D?

☐ Yes ☐ No

Do you live in the United States?

☐ Yes ☐ No

For JYNARQUE® (tolvaptan) APPLICANTS ONLY: Are you applying for Temporary Patient Assistance while your insurance makes a benefit determination?

☐ Yes ☐ No

For JYNARQUE® (tolvaptan) APPLICANTS ONLY: If you are new to JYNARQUE, would you like a JYNARQUE Starter Kit that provides educational and support information?

☐ Yes ☐ No

SECTION 4: FINANCIAL ELIGIBILITY

Please complete the information below for income and house-hold size.

Annual household income before taxes* | Number of persons living in household, including yourself

Applicant must include proof of income for all contributing members of the household with the application submission. Please submit ONE of the following for each contributing members:

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

The Applicant must provide proof of residency documentation. Please submit ONE of the following documents with this application:

- Social Security number
- State driver's license
- US birth certificate
- US passport
- Foreign passport with US visa
- I-94 form with photograph
- US military ID
- US certificate of naturalization or citizenship

JYNARQUE® (tolvaptan) tablets

Samsca® (tolvaptan)

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for JYNARQUE and SAMSCA at www.jynarque.com, www.samsca.com or call 1-800-441-6763.

OTSUKA PATIENT ASSISTANCE PROGRAM APPLICATION FORM (CONT'D)

SECTION 5: PROVIDER INFORMATION

First name

Last name

State license # | DEA # | NPI #

Tax ID # | Facility type

Facility name

Address

City | State | Zip

PRIMARY CONTACT

First Name | Last Name

Phone | Ext | Fax

Email

SECTION 6: PRESCRIPTION INFORMATION

NY, NJ, IA physicians must supply a prescription per state regulations

Patient first name

Patient last name

Patient ICD-10 code

Patient DOB (mm/dd/yyyy)

For SAMSCA® (tolvaptan) ONLY

Date of patient's hospital admission | Date of patient's hospital discharge or expected discharge:

Number of SAMSCA tablets administered during the hospital stay:

Number of SAMSCA tablets dispensed at hospital discharge:

Dosage (mg) | Quantity

Directions

Titration directions, if needed

For JYNARQUE® (tolvaptan) ONLY

Is the patient enrolled in the REMS program for JYNARQUE?

☐ Yes ☐ No | REMS ID

Dosage (mg) | Quantity | Number of refills

Directions

Titration directions, if needed

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 3640, Gaithersburg, MD 20885-3640. I understand that OPAF may revise, change, or terminate programs at any time.

☐ **Dispense as written**

Prescriber's Name

Prescriber's Signature | Date (mm/dd/yyyy)

JYNARQUE® (tolvaptan) tablets

Samsca® (tolvaptan)

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for JYNARQUE and SAMSCA at www.jynarque.com, www.samsca.com or call 1-800-441-6763.