Reset Form

Patient Assistance Foundation

Application Form

Otsuka PATIENT ASSISTANCE FOUNDATION

The Otsuka Patient Assistance Foundation provides patients with prescribed Otsuka medication free of cost. Eligible patients can receive no-cost ABILIFY® (aripiprazole) Tablets, ABILIFY MAINTENA® (aripiprazole), JYNARQUE® (tolvaptan), REXULTI® (brexpiprazole), or SAMSCA® (tolvaptan).

How to complete this application form

Patient (or legal authorized representative) must do the following:

- Read and sign the patient authorization (section 1), and fill out sections 2 through 5
- Include documentation that outlines the amount spent for prescription medicine in the relevant benefit year. Examples of documentation include: letter from plan provider, explanation of benefits (EOB), or clearly dated pharmacy printout showing amount paid for each medicine

The prescribing healthcare provider must do the following:

- Complete sections 6 and 7, including prescription with prescriber's signature
- **NY & NJ physicians must attach an appropriate prescription**

How to submit this application form

There are two convenient ways to submit the completed form:

- **Fax to 1-844-727-6274**
- Mail to Otsuka Patient Assistance Foundation, PO Box 3640, Gaithersburg, MD 20885-3640

*For additional assistance, please contact the Dedicated Patient Coordinator by dialing **1-855-727-6274**.*

To be completed by the patient

SECTION 1. PATIENT AUTHORIZATION

I (patient and/or legal authorized representative) authorize that my (or the patient's) protected health information (PHI) may be sent to the Otsuka Patient Assistance Foundation, Inc. (hereafter referred to as OPAF), disclosed to and reviewed by Otsuka and its authorized representatives and vendors, as described above, and disclosed to others by OPAF, including:

- Information provided on this form
- My healthcare records related to my treatment and condition(s)
- Payer-related information received from my health insurer
- Prescription, fulfillment, and shipment information from pharmacies or other relevant sites of care
- Hospitalization details and information to help support my transition of care

In addition, I (or I on behalf of the patient) authorize OPAF to use my information for internal data collection and reporting purposes, to track coverage, cost-share and payer-related trends, for utilization of OPAF offerings, and to assess ongoing and future needs of patients who are prescribed Otsuka products and diagnostic testing that is needed for safe use of those products.

I acknowledge that my (or the patient's) household income and the number of people in my (or the patient's) household have been accurately reported on this form 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.

My authorization and notice of release will remain in effect for two (2) years 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 or diagnostic testing. 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.

After you have signed this consent, you may withdraw it by **calling OPAF at 1-855-727-6274** or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation, PO Box 3640, Gaithersburg, MD 20885-3640. If you choose not to sign this authorization or you withdraw it after signing this form, OPAF will not be able to provide you with support after the date of your revocation.

_____ _____

Patient Name or Legal Authorized Representative | Relationship to Patient

sign here _____ ____ / ____ / ____

Signature of Patient or Legal Authorized Representative | Date

ABILIFY® (aripiprazole) TABLETS

Abilify Maintena® (aripiprazole) for extended release injectable suspension

JYNARQUE® (tolvaptan) tablets

REXULTI® brexpiprazole tablets

Samsca® (tolvaptan)

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for ABILIFY, ABILIFY MAINTENA, JYNARQUE, REXULTI, and SAMSCA.

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Otsuka PATIENT ASSISTANCE FOUNDATION

To be completed by the patient

SECTION 2. PATIENT DEMOGRAPHIC INFORMATION

☐ **Check if copy of demographic/fact sheet is attached. You must still fill in your first name, last name, and DOB below.**

All fields are required, except those labeled *optional*.

First name: _____ Last name: _____ MI: _____

DOB: ____ / ____ / ____ SSN: _____ - _____- _____ Gender: ☐ M ☐ F

Patient address: _____

City: _____ State: _____ ZIP: _____

Preferred language *(optional)*: _____ Email *(optional)*: _____

Patient primary phone number: (_____) _____ - _____

☐ **Check if there is a primary caregiver or an alternate contact. (All fields required if this box is checked.)**

Caregiver/alternate contact name: _____ Relationship: _____

Caregiver primary phone number: (_____) _____ - _____

SECTION 3. PATIENT INSURANCE INFORMATION

All fields are required, except those labeled *optional*.

☐ I do not have insurance (skip to section 4).

☐ I am attaching copies of all my insurance and prescription cards.

☐ Information is the same on medical and prescription card. If so, only fill out Medical Card section below.

If you are not attaching copies of your insurance cards, please fill out the following section:

Patient first name: _____ Patient last name: _____ Patient DOB: ____ / ____ / ____

Medical Card

Payer name: _____ Plan name *(optional)*: _____

Phone: (_____) _____ - _____ Policyholder name: _____

Member ID: _____ Group # *(optional)*: _____ Policyholder DOB *(optional)*: ____ / ____ / ____

Prescription Card

Payer *(optional)*: _____ Member ID # *(optional)*: _____

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Otsuka PATIENT ASSISTANCE FOUNDATION

To be completed by the patient

All fields are required, except those labeled *optional*.

Patient first name: _____ Patient last name: _____ Patient DOB: ____ / ____ / ____

SECTION 4. INSURANCE ELIGIBILITY INFORMATION

Do you have insurance or any prescription drug coverage?
(If YES, please attach copies of your insurance cards or complete section 3.) ☐ Yes ☐ No

Have you been denied coverage by a health or medical 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

Do you have a physical street address (not a PO box) to receive shipment? ☐ Yes ☐ No

SECTION 5. FINANCIAL ELIGIBILITY INFORMATION

All fields are required, except those labeled *optional*.

Patient first name: _____ Patient last name: _____ Patient DOB: ____ / ____ / ____

Please complete the information below for income and household size.

Annual household income before taxes*: **$** _____

Number of persons living in household, including yourself: _____

Annual prescription costs (required if you have insurance): **$** _____

If you have Medicare Prescription Drug Coverage (Part D) and cannot afford your medication, you may be eligible for assistance. Please provide photocopy documentation showing what you have spent on prescription medicine for the relevant benefit year (letter from plan provider, explanation of benefits (EOB), or clearly dated pharmacy printout showing amount paid for each medicine).

*Includes salary/wages, Social Security income, unemployment insurance benefits, disability income, interest/dividends, and any other income for the household.

THE PATIENT SECTION OF THE FORM IS COMPLETE. PLEASE HAVE YOUR DOCTOR FILL OUT THE REST OF THIS APPLICATION.

Otsuka PATIENT ASSISTANCE FOUNDATION

To be completed by the prescribing healthcare provider

SECTION 6. PRESCRIBER INFORMATION

All fields are required, except those labeled *optional*.

☐ Cardiologist ☐ Internal medicine ☐ Nephrologist ☐ NP ☐ Oncologist ☐ PA ☐ Psychiatrist

☐ Other: _____

Provider's first and last name: _____

State license #: _____ DEA #: _____ NPI #: _____

Site name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Provider's direct phone: (_____) _____ - _____ Ext: _____ Provider's fax: (_____) _____ - _____

Provider's email *(optional)*: _____

SECTION 7. PRESCRIPTION INFORMATION

New York and New Jersey physicians must attach an appropriate prescription.

All fields are required, except those labeled *optional*.

Patient first name: _____ Patient last name: _____ Patient DOB: ____ / ____ / ____

ICD-10 code: _____ Drug name: _____

Patient allergies: _____

A. DOSAGE - Check the box that applies and complete all applicable dosage information:

For ABILIFY® (aripiprazole) Tablets, JYNARQUE® (tolvaptan), REXULTI® (brexpiprazole), and SAMSCA® (tolvaptan):

Date of patient's admittance (if applicable): ____ / ____ / ____

Date of patient's discharge or expected discharge (if applicable): ____ / ____ / ____

☐ Oral tablets/Dosage (mg/day): _____ Days supply: ☐ 30 ☐ 60 ☐ 90 Number of days: ____ Number of refills: ____

For ABILIFY MAINTENA® (aripiprazole) ONLY

☐ Injection/Dosage: _____ Quantity: _____ ☐ Dual-Chamber Syringe ☐ Vial Kit Number of refills: _____

Directions: _____

Titration directions, if needed: _____

Prescriber's signature required (NO STAMPS). I certify that therapy with the above-mentioned product or diagnostic testing 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 and dispense the requested medication or ordered test. I authorize and appoint OPAF to convey on my behalf any prescription information delivered to OPAF or to the dispensing pharmacy or testing facility chosen by or for the patient. I am directing the pharmacy selected by the patient or OPAF to dispense and/or administer the pharmaceutical product I have prescribed or the diagnostic test I have ordered.

_____
Prescriber's Name

sign here ☐ Dispense as written. _____ ____ / ____ / ____
Prescriber's Signature Date

I appoint the Otsuka Patient Assistance Foundation to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for ABILIFY, ABILIFY MAINTENA, JYNARQUE, REXULTI, and SAMSCA.

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To be completed by the prescribing healthcare provider

I appoint the Otsuka Patient Assistance Foundation to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

SECTION 7. PRESCRIPTION INFORMATION (cont'd)

All fields are required, except those labeled *optional*.

Patient first name: _____ Patient last name: _____ Patient DOB: ____ / ____ / ____

B. REFERRING SITE OF CARE

Site name: _____

Contact's first and last name: _____

Preferred method of contact: ☐ Phone ☐ Fax

Direct phone: (_____) _____ - _____ Ext: _____ Fax: (_____) _____ - _____

Alternate phone: (_____) _____ - _____ Alternate fax: (_____) _____ - _____

Address: _____

City: _____ State: _____ ZIP: _____

Type of site care:

☐ Inpatient facility ☐ Clinical trial site ☐ Correctional facility ☐ Outpatient clinic ☐ Unknown

C. RECEIVING SITE OF CARE

To be filled out only if different from provider listed in section 6.

Type of facility:

☐ Inpatient facility ☐ Clinical trial site ☐ Correctional facility ☐ Outpatient clinic ☐ Unknown

Date of last injection: ____ / ____ / ____ Date of next injection (if scheduled): ____ / ____ / ____

Treating healthcare provider name: _____

Treating site name: _____

Phone: (_____) _____ - _____ Ext: _____ Fax: (_____) _____ - _____

State license #: _____

DEA #: _____ NPI #: _____

Address: _____

City: _____ State: _____ ZIP: _____

D. LIST OF INJECTION CENTER LOCATIONS [for ABILIFY MAINTENA® (aripiprazole) only]

Please send me a list of injection centers: ☐ Closest to me ☐ Closest to my patient

☐ Please use the following approved injection center location: _____

Address: _____

City: _____ State: _____ ZIP: _____

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for ABILIFY MAINTENA.

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