Patient Enrollment Form for REXULTI® (brexpiprazole)

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Fax completed forms to: 1 (844) 687-8528
Phone: 1 (844) 687-8526 | Address: PO Box 220684, Charlotte, NC, 28222-0684

1. PRESCRIBER INFORMATION

Prescriber Name: License #: State Licensed:

Facility Address: Tax ID #: NPI #:

City: State: Zip: Phone: ( ) - Fax: ( ) -

Facility name: Email:

Facility primary contact: Alt Contact Name:

Contact Phone: ( ) - Alt. Contact Phone: ( ) -

2. PATIENT INFORMATION

First: MI: Last: Phone: ( ) -

Gender: ◯ M ◯ F DOB: SSN: Cell: ( ) -

Address: City: State: Zip:

Alternate Patient Contact (optional)

The below contact information will be used to coordinate care support if the patient cannot be reached or is unable to manage his/her care. Examples of alternate patient contacts include, but are not limited to, caregivers, guardians, and conservators. Please see page 2 for Patient Authorization.

Name: Phone: ( ) -

Relationship to Patient:

3. PRESCRIPTION INFORMATION & PRESCRIBER AUTHORIZATION

Support will only be provided for patients whose prescription is consistent with an FDA-approved indication.

Primary Diagnosis Code: (See back of cover sheet for ICD-9 and ICD-10 code descriptions; option to provide additional code information, if available, in spaces below)

☐ 295.0__/F20.89 ☐ 295.1__/F20.1 ☐ 295.2__/F20.2 ☐ 295.3__/F20.0

☐ 295.5__/F20.89 ☐ 295.6__/F20.5 ☐ 295.8__/F20.89

☐ 295.9__/F20.3 or F20.9 ☐ 296.2__/F32.__ ☐ 296.3__/F33.__

Secondary Diagnosis Code:_______________________________________

Prescribed dose of REXULTI® (brexpiprazole):

Dosage:

Quantity: Refills:

Directions:

I certify that the treatment listed above is and will be medically necessary based on my best professional judgment and that the information provided in this form is complete and accurate to the best of my knowledge. I also certify that I have obtained patient consent for the disclosure of protected health information (PHI) as required by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and any other legally required consents of the patient (or the patient's legal representative) for the release of the patient's information to the ASSURE Program (the "Program") and Otsuka America Pharmaceutical, Inc. and/or its representatives or agents (collectively, "OAPI"), as may be necessary for the patient's participation in the Program and for the Program and OAPI to use and disclose such information as necessary to provide reimbursement support and other related information and resources to me and my patient in connection with the patient's therapy. I attest that I am not on the HHS/OIG list of Excluded Individuals and that I am authorized under State law to prescribe and dispense the requested medication. I authorize and appoint the Program and OAPI to convey on my behalf any prescription information delivered to the Program to the dispensing pharmacy chosen by or for the patient. I understand that the Program and OAPI will use and disclose this information only in connection with the Program, including but not limited to performing a preliminary verification of the patient's insurance coverage for REXULTI® (brexpiprazole) and triage to OAPI's Patient Assistance Program ("PAP") if applicable, and as otherwise required or permitted by law. I further certify that (a) any support provided through the Program on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use REXULTI® (brexpiprazole) or any other OAPI product or service, and (b) my decision to prescribe REXULTI® (brexpiprazole) was based on my determination of medical necessity as set forth herein. I agree that the Program and OAPI may contact me for additional information relating to the Program or REXULTI® (brexpiprazole), including but not limited via email, fax and telephone. I understand that OAPI reserves the right, at any time and without notice, to modify or discontinue the Program. I understand that completing this enrollment form does not ensure that the patient will obtain insurance coverage or reimbursement for my prescription, and that any support provided through the Program are provided for information purposes only and represent no statement, promise or guarantee by the Program or OAPI. I agree that in no event shall OAPI be liable for any damages resulting from or relating to the Program. I am directing the retail pharmacy selected by my patient to administer the pharmaceutical product I have indicated.

Sign Here ✖

Prescriber's Signature (required) Printed Name Date

Please see accompanying Important Safety Information on the inside of the front cover and Full Prescribing Information for REXULTI® (brexpiprazole), including **Boxed WARNING**.

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ASSURE™

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4. PATIENT INSURANCE INFORMATION

ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD(S) OR COMPLETE BELOW

Primary Insurance

Plan Name: Policy #: Group #:

Policy Holder DOB: Policy Holder (or relationship): Insurance Phone: ( ) -

Primary Prescription Plan (IF PATIENT HAS ADDITIONAL PRESCRIPTION COVERAGE, PLEASE COMPLETE)

Plan Name: Policy #: Group #:

Policy Holder DOB: Policy Holder (or relationship): Insurance Phone: ( ) -

BIN: PCN:

Secondary Insurance

Plan Name: Policy #: Group #:

Policy Holder DOB: Policy Holder (or relationship): Insurance Phone: ( ) -

Secondary Prescription Plan

Plan Name: Policy #: Group #:

Policy Holder DOB: Policy Holder (or relationship): Insurance Phone: ( ) -

BIN: PCN:

5. PATIENT AUTHORIZATION

☐ I would like to receive periodic text messages from ASSURE for reminders surrounding:

☐ My medication ☐ Treatment reminders

☐ Other ASSURE-related matters and information

I would like to receive these reminders: ☐ 1st of every month ☐ 15th of every month

(if you do not make a selection it will default to the 1st of every month)

If you authorize any of the above text messaging, it is important to note that ASSURE does not substitute for or provide medical/treatment advice, and I will continue to direct my treatment-related questions to my physician. I understand that I can stop future communications for this service at any time by calling 1 (844) 687-8526, mailing a signed written statement of my revocation to PO Box 220684, Charlotte, NC, 28222-0684, or replying directly to an ASSURE text message reminder with a text message containing my revocation statement. In addition, if I have provided an alternate patient contact on page 1, I give ASSURE permission to send text message reminders around my medication to my alternate patient contact.

☐ I authorize my healthcare provider, health insurer, pharmacist and other relevant third parties to disclose to Otsuka America Pharmaceutical, Inc. ("OAPI") and/or its agents (collectively, OAPI), and OAPI to use, my protected health information, including but not limited to insurance information, diagnosis, prescriptions and my city and state (together my "Protected Health Information") for purposes of internal data collection and analytic efforts. I understand that I can stop future sharing of my Protected Health Information for data collection and analytics purposes at any time by calling 1 (844) 687-8526 or by mailing a signed written statement of my revocation to PO Box 220684, Charlotte, NC, 28222-0684. I understand that revoking this authorization will prohibit disclosures after the date revocation is received, except to the extent that action has already been taken in reliance on this authorization.

☐ I understand that OAPI or approved parties acting on its behalf may use the information I am providing to send me information and offers that may be of interest to me. OAPI will not sell or transfer my information to any unauthorized third parties. I understand that from time to time OAPI's privacy policy may change and that I should check OAPI's website for the most recent version of the privacy policy. I can request to stop receiving OAPI marketing communications by calling 1 (855) REXULTI or by going to the following website **https://www.REXULTI.com/us/unsubscribe**.

☐ **I understand that:**

- This authorization is entirely optional. I may decline to provide this authorization and still participate in the Otsuka Patient Assistance Program. My healthcare providers will not condition my medical treatment on my agreement to provide this authorization.
- This authorization will continue indefinitely until I revoke it as described above.
- Once my Protected Health Information is released based on this authorization, Federal and State privacy laws may not prevent the entities described above from re-disclosing my Protected Health Information, although they have agreed to only use or disclose information received for purposes described in this authorization or as otherwise permitted or required by law.
- I can request a copy of this authorization.

Sign Here ✕

Patient or Legal Authorized Representative Printed Name Year of Birth Date

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Otsuka