Patient Consent Form

Patient Authorization

By signing below, I am enrolling in the Otsuka Patient Support program. I authorize Otsuka and its affiliates, business partners, vendors and other agents to provide me with services for which I am eligible under this program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the program's offerings, I agree to my enrollment in the assistance program if I am eligible.

☐ I understand that to be eligible for commercial copay assistance I must have commercial insurance that covers medication costs and not be enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare, Medicaid, TRICARE, or any other federal or state healthcare plan, including state pharmaceutical assistance programs. I understand and agree that a benefit verification will be performed and commercial copay savings assistance will not be provided if eligibility cannot be verified.

Patient Name _____ **DOB** _____

Signature of Patient _____ **Date** _____

Legal Representative Name _____ **Legal Representative Signature** _____

If signed by patient legal representative, provide authority to sign on behalf of the patient.

I understand that Otsuka and its business partners may use and share with each other and with my healthcare providers, pharmacies, and health insurance plans, my information in connection with providing services to me under the program, administering the program, or as otherwise required for Otsuka to meet its legal obligations.

I authorize that my PHI may be sent to Otsuka Patient Support by my healthcare provider and pharmacy, disclosed to and reviewed by Otsuka and its authorized representatives and vendors of Otsuka, including Otsuka Patient Support call center staff, as necessary to provide the support available, including transition of care support. This includes sending my PHI as provided by my healthcare provider and pharmacy to my health insurers, pharmacies, advocacy organizations, and third parties such as data aggregators, copay card vendors, laboratories, safety program administrators, patient access centers, and the patient assistance program pharmacy. There is a potential for the information to be subject to re-disclosure by the recipient and no longer protected by HIPAA.

My PHI may include:

- information provided on this form
- healthcare records related to my treatment and health condition(s)
- payer-related information received from my health insurer
- prescription, fulfillment, shipment, and other information provided by pharmacies or other sites of care
- information to help support my transition of care

My authorization and notice of release will remain in effect for one (1) year from the date of my signature. I understand that I may be requested to provide my written consent on a biannual basis by the program in an effort to support continued access to prescribed treatment. I understand that my pharmacy may receive payment from the Program for providing the support services outlined in this consent as authorized in this consent. Signing this consent form is voluntary. I understand that 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 I have signed this consent, I may withdraw it by calling Otsuka Patient Support at **888-564-9611** or by sending a written notice to **Patient Consent Management, PO Box 61204, King Of Prussia, PA 19406 with the following information:**

- Authorization Revocation, Patient First Name, Patient Last Name, Patient Date of Birth, Contact Phone Number, Contact Address

The withdrawal 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 withdrawal. If I choose to not sign this authorization or I withdraw it after signing this form, Otsuka Patient Support will not be able to provide me with the support described above after the date of my revocation. I understand that if I withdraw, it will not have any effect on any uses or disclosure of my information that occurred prior to receiving my withdrawal.

Information about the Otsuka privacy policy and information about your rights concerning your data, can be found at otsuka-us.com/oapi-and-opdc-privacy-policy.

☐ *By completing the contact information on the right, the patient agrees that protected health information may be shared with the person named on the right.*

Caregiver/ alternate Contact Name _____ **Relationship** _____

Phone _____ **Mobile** _____

Standard mobile carrier rates for voice and text messaging apply.

Patient Name _____ **DOB** _____

Signature of Patient _____ **Date** _____

Legal Representative Name _____ **Legal Representative Signature** _____

If signed by legal representative, indicate the relationship to the patient and your authority to act for the patient.

☐ **AllianceRx Walgreens Prime**

alliancerxwp.com

130 Enterprise Drive,
Pittsburgh, PA 15275

Phone: (800) 480-9052
Fax: (877) 231-8302
Hours (EST): **M-F:** 8AM-7PM, **SAT:** 9AM-3PM, **SUN:** Closed
NPI: 1972560688

☐ **Optum (Avella)**

avella.com

24416 N 19th Avenue,
Phoenix, AZ 85085

Phone: (877) 719-6330
Fax: (877) 546-5780
Hours (EST): **M-F:** 6AM-6PM, **SAT:** 9:30AM-12:30PM, **SUN:** Closed
NPI: 1780030163

☐ **PANTHERxRare**

pantherxrare.com

24 Summit Park Drive,
Pittsburgh, PA 15275

Phone: (833) 599-2245
Fax: (855) 246-3986
Hours (EST): **M-F:** 8AM-8PM, **SAT:** 9AM-3PM, **SUN:** Closed
NPI: 1316213531

Otsuka
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