OTSUKA PATIENT EDUCATION LIAISON ENROLLMENT FORM

Fax: 1-240-514-3999

All fields required unless noted

1 PATIENT INFORMATION (to be completed and signed by patient)

Patient's Name (First, MI, Last) | Cell Phone | Home Phone

Date of Birth (MM/DD/YYYY) | Sex: ☐ M ☐ F | *OK to leave message about Otsuka on* ☐ Cell Phone (Used for text if requested) ☐ Home Phone

Street Address | Preferred Language ☐ English ☐ Spanish ☐ Other

City | State | ZIP Code

E-mail

2 PRESCRIBER INFORMATION (to be completed by patient)

Prescribing Physician Name | Practice | Phone Number

3 OTSUKA PRODUCT you are currently prescribed or will be taking (to be completed by patient)

Write product name here

If you are using an injectable drug, please complete the below:

Outpatient Prescriber/New Site of Care

Pharmacy

Last Injection Date (if known)

Appointment Date (if known)

4 TELEPHONE COMMUNICATION & TEXT MESSAGES CONSENT

Please read the following carefully and check the indicated box.

Telephone Communication & Text Messages Consent

I consent to receive ☐ **calls** and/or ☐ **texts** from and on behalf of Otsuka America Pharmaceutical, Inc., made with an autodialer or prerecorded voice, at the phone number(s) provided. You understand that your consent is not required or a condition of the program. The number of messages will vary based on your program selections. By consenting to text messages, you understand that although every effort is made to protect information, SMS/Text messages may not be secure. Message and data rates may apply. For additional information, see Otsuka America Pharmaceutical Privacy Policy at: otsuka-us.com/oapi-and-opdc-privacy-policy. Text STOP to opt out and HELP for help.

☐ I consent to participate in the Otsuka Patient Education Liaison Program.

SIGN HERE

PATIENT/LEGAL GUARDIAN SIGNATURE
— If legal guardian, please state the relationship to the patient

Date (MM/DD/YYYY)

Otsuka

Otsuka America Pharmaceutical, Inc.

Otsuka Patient Support™

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5 PATIENT AUTHORIZATION

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 Protected Health Information (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 or for providing the support services outlined in this consent as authorized in this consent. Signing this consent form is voluntary.

The Otsuka privacy policy governs the use of the information you provide and your rights regarding your data, and can be found at otsuka-us.com/oapi-and-opdc-privacy-policy.

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 (revoke) 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 disclosures of my information that occurred prior to receiving my withdrawal.

By completing the contact information below, the patient agrees that protected health information may be shared with the person named below and that the person named below agrees to be called by the Program, in reference to the patient, at which point they can agree to be contacted by the Program via text. If the patient no longer wants to share their information, the person named below will continue to be contacted by the Program in reference to the patient unless the patient indicates otherwise.

SIGN HERE

PATIENT/LEGAL GUARDIAN SIGNATURE (I have read and agree to the Patient Authorization) — If legal guardian, please state the relationship to the patient | Date (MM/DD/YYYY)

Caregiver/Alternate Contact Name | Relationship | Cell Phone

Additional Caregiver/Contact Name | Relationship | Cell Phone

Standard mobile carrier rates for voice and text messaging apply.

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