UCB, INC. PATIENT ASSISTANCE PROGRAM APPLICATION

Inspired by patients.
Driven by science.

Fax #: (855) 880-5262
Phone #: (877) 785-8906

UCB Patient Assistance Program

The UCB Patient Assistance Program currently supports the following products.

CIMZIA® (certolizumab pegol)

BRIVIACT® (brivaracetam) CV

VIMPAT® (lacosamide) CV

NEUPRO® (rotigotine transdermal system)

NAYZILAM® (midazolam) nasal spray CIV

Eligibility

Assistance for UCB products may be available to patients with a valid prescription from a U.S. licensed health care practitioner. The program is not intended for clinics, hospitals and/or other institutions. The minimum eligibility requirements are as follows:

- Patient must reside in the United States, the District of Columbia or Puerto Rico
- Patient must be uninsured or if insured, have significant financial hardship despite insurance coverage
- Insured patients who cannot afford their medication will be considered only after exhausting all other coverage options: For example, Medicare patients must be denied for the Low Income Subsidy (LIS) in order to be considered for the program.
- Cimzia patients with government insurance, such as Medicare and TRICARE are not eligible for the patient assistance program
- All applications must include a valid prescription from a U.S. licensed healthcare practitioner
- Prescriptions for Briviact CV, Vimpat CV and Nayzilam CIV must be signed by an MD or DO in compliance with Texas Pharmacy Regulations, where the PAP pharmacy is located
- A patient's total household income cannot exceed 500% of the Federal Poverty Limit (FPL). Detailed information on the current Federal Poverty Limit can be found at the following web URL address: https://www.healthcare.gov/glossary/federal-poverty-level-FPL

All information provided in this application is subject to verification.

Application

If you believe you meet the minimum requirements for program eligibility, please complete sections 1 and 2 of this application, then have your physician complete section 3. If you believe you do not meet the minimum requirements listed above you may not qualify for the UCB Patient Assistance Program; however, you may contact UCB**Cares** by calling 844-599-CARE (2273) to see if there are other financial resources available to you.

- Patient or patient representative completes Sections 1 and 2. Proof of income section MUST be completed and signed in order for application to be processed
- Physician completes Section 3 and submits application along with a written prescription for the requested UCB product.

Please do not submit additional or unrequested medical information, chart notes or supporting medical documentation.

UCB, INC. PATIENT ASSISTANCE PROGRAM APPLICATION

Inspired by patients.
Driven by science.

Fax #: (855) 880-5262
Phone #: (877) 785-8906

SECTION 1 Patient Information (to be completed by the patient or authorized patient representative)

Please print clearly. All fields required. Please note all requested information must be completed in order to avoid delay or possible denial of your application. For applicants requesting VIMPAT® CV, BRIVIACT® CV or NAYZILAM® CIV, please also include a valid, current driver's license number for the patient/authorized patient representative or an official government issued ID number.

Patient First Name: _____

Patient Last Name: _____

Date of Birth: _____/ _____/ _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Is the address above your shipping address?: ☐ Yes or ☐ No If the answer is No provide shipping address below.

Patient Email Address: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Does the patient currently reside in the U.S.?: ☐ Yes or ☐ No **Sex:** ☐ Male or ☐ Female

Social Security #: _____ - _____ - _____ or if applicable **Alien ID #:** _____

Patient Preferred Language: _____

If requesting VIMPAT, BRIVIACT and Nayzilam please provide the following information found on a current official government ID

ID Type_____ **ID#**_____**State:**_____

Do you have prescription drug coverage?: ☐ Yes or ☐ No or ☐ Unknown

If you answered yes above, please answer the questions below.

Insurance Plan Name: *(e.g., Humana, Blue Shield, United, Aetna, etc.)*

_____

Insurance Plan ID Number: _____

Insurance Plan Contact Number: _____

Do you have Medicare Part D?: ☐ Yes or ☐ No **Medicare ID #:** _____

Alternate Contact: By providing this information, you consent to UCB program administrators sharing or discussing your private health information with this person. Please list no more than two (2) persons authorized to discuss your private health information with UCB program administrators. This may include health care professionals or medical office staff.

First and Last Name: _____

Relationship: _____ **Phone:** _____

First and Last Name: _____

Relationship: _____ **Phone:** _____

Please do not submit additional or unrequested medical information, chart notes or supporting medical documentation.

UCB, INC. PATIENT ASSISTANCE PROGRAM APPLICATION

Inspired by patients.
Driven by science.

Fax #: (855) 880-5262
Phone #: (877) 785-8906

SECTION 2 Income Information

Gross Monthly Household Income: Please include your TOTAL GROSS MONTHLY HOUSEHOLD income. If that income comes from salary/wages/dividends, Social Security, supplemental income, disability, unemployment compensation, pension/annuity, alimony/child support, rental income or other (please specify), indicate the dollar amount. If there is NO household income, please submit a letter with this application (signed and dated by the patient or patient's authorized representative) to explain that the patient receives no income.

Signature and Date: You or your authorized patient representative must sign and date this application.

All reported income will be verified by consumer credit agencies. Where income verification is not possible, patients will be required to provide proof of income.

List All Sources, *Gross Monthly* Amounts

Salary/Wages:	$ .00	Social Security:	$ .00
Child Support /Alimony:	$ .00	Disability:	$ .00
Retirement:	$ .00	Social Security Pension/ Unemployment:	$ .00
Work Comp:	$ .00	**Total Gross Household Monthly Income:**	$ .00

Number of persons DEPENDENT upon primary income within the family: _____

Applicant Declarations

By signing here, patient or authorized representative agrees to all stated declarations and authorization for use and disclosure of protected health information below.

_____ _____

Patient's (or authorized patient representative) Signature: **Date:**

I certify and promise that: all information provided in this application is complete and accurate, including all information regarding my income; I am authorized to sign this application; and I will contact the UCB Patient Assistance Program (Program) if any of my information about my income, financial status, prescription drug coverage, or insurance changes. If audited, I agree to provide the necessary documents to support the information on this application.

I understand that completing this application does not ensure that I will qualify for this Program and that the Program assistance will terminate if UCB or its agents become aware of any fraud or if the UCB medication being provided is no longer prescribed for me. I also understand that UCB reserves the right to modify the application form, modify or discontinue the Program, or terminate assistance at any time and without notice.

Authorization for Use and Disclosure of Protected Health Information

I understand that in order for the UCB Patient Assistance Program to provide me with assistance, it will need to obtain, review, use, and disclose my personal health information (PHI), including information relating to my medical condition and information on my application form. Should an investigative consumer report be utilized, you will have the right to request a complete and accurate disclosure of the nature and scope of the investigation requested and a written summary of your rights under the Fair Credit Reporting Act. I agree to allow the Program to contact me via mail, telephone or email to carry out these services.

I authorize my physician(s), pharmacy, and my health plan(s) to share information about me or my medical condition, including my PHI, with the UCB Patient Assistance Program, UCB, and/or their agents, which may administer the Program. This information will be used and shared to determine whether I am eligible for insurance coverage or other reimbursement for the medication(s) for which I am applying, whether I am eligible for the Program, to administer the Program, and to assess the quality of Program services provided by UCB, its vendors and its contractors. I understand that once the Program receives my information, it may be re-disclosed and no longer protected by federal privacy regulations.

I understand that if I do not sign this authorization or if I cancel it, I cannot participate in the Program. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician, and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization.

I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

UCB, INC. PATIENT ASSISTANCE PROGRAM APPLICATION

Inspired by patients.
Driven by science.

Fax #: (855) 880-5262
Phone #: (877) 785-8906

SECTION 3 Prescriber Information (to be completed by prescribing physician)

A valid prescription must be provided by your healthcare professional

Physician Full Name: _____

Office Contact Full Name: _____

Address: (No P.O. Box) _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

DEA #: _____ **NPI #:** _____

State License #: _____ **Exp Date:** _____ - _____ - _____

Patient First and Last Name: _____

Known Allergies: _____

Concomitant medication(s) patient is taking: _____

_____

_____

_____

Please check the approrpriate box (es) below for drug name and dose selection. Medication quantitiy will be determined by the accompanying prescription, upon approval. Approvals may be valid for up to 24 months and may periodically require verification.

THIS FORM IS NOT A PRESCRIPTION. PLEASE INCLUDE A COMPLETE PRESCRIPTION WITH THIS APPLICATION.

Prescriptions for Briviact CV, Vimpat CV and Nayzilam CIV require MD or DO signature in compliance with Texas Pharmacy Regulations.

Nayzilam® CIV	CIMZIA®	VIMPAT® CV Tablets and Oral Solution	BRIVIACT® CV Tablets and Oral Solution	NEUPRO® Transdermal System
☐1 Kit 2 x 5mg Nasal Spray Unit	☐ CIMZIA Starter Kit 6- 200mg/mL PFS	☐ VIMPAT 50mg	☐ BRIVIACT 10mg	☐ NEUPRO 1mg/24hr
	☐ CIMZIA Starter Kit 2- 200mg/mL PFS	☐ VIMPAT 100mg	☐ BRIVIACT 25mg	☐ NEUPRO 2mg/24hr
	☐ CIMZIA LYO 2-200mg/mL Vials +2 Vials	☐ VIMPAT 150mg	☐ BRIVIACT 50mg	☐ NEUPRO 3mg/24hr
		☐ VIMPAT 200mg	☐ BRIVIACT 100mg	☐ NEUPRO 4mg/24hr
		☐ VIMPAT 10mg/mL	☐ BRIVIACT 10mg/mL	☐ NEUPRO 6mg/24hr
				☐ NEUPRO 8mg/24hr

UCB, Inc.
UCB Patient Assistance Program
2730 S. Edmonds Lane
Suite 300
Lewisville, TX 75067

Fax #: (855) 880-5262
Phone #: (877) 785-8906
Email: ucb-pap@cardinalhealth.com

Please do not submit additional or unrequested medical information, chart notes or supporting medical documentation.