PRESCRIPTION AND SERVICE REQUEST FORM (PSRF)

FOR UZEDY® (RISPERIDONE) EXTENDED-RELEASE INJECTABLE SUSPENSION

Please fax **COMPLETED** form to **1-877-228-4190**
Questions? Call **1-800-887-8100** (9am to 8pm ET, M-F)

teva | Shared Solutions

Teva Shared Solutions® can help you plan for starting and staying on UZEDY. We can help you–or your caregiver–figure out your insurance, Medicare, or Medicaid coverage and find financial assistance options. Shared Solutions can also help you find an injection site near your home or work. Plus, we provide over-the-phone nurse support for questions or concerns you or your caregiver may have about UZEDY.

SELECT WHICH PROGRAM SERVICES PATIENT IS SEEKING:

☐ Benefit verification ☐ Prescription fulfillment ☐ Site of Care finder ☐ Co-pay Savings Program (for commercially insured patients only)

SECTION 3 MUST BE COMPLETED BY PATIENT OR PERSONAL REPRESENTATIVE

1 PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____ DOB (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

ALTERNATIVE PATIENT CONTACT/CAREGIVER NAME: _____ Relationship to Patient: _____ Phone: _____ Email: _____

2 PATIENT INSURANCE INFORMATION

Must include copy of insurance card and pharmacy benefit card (front and back) when submitting

PRIMARY INSURANCE: ☐ Medicare ☐ Medicaid ☐ VA/Military Benefits ☐ Commercial/Private Insurance ☐ I do not have insurance

Policyholder Name: _____ DOB (MM/DD/YYYY): _____ Relationship to Patient: _____

Insurance Name: _____ Phone: _____ ID/Policy #: _____ Group #: _____

SECONDARY INSURANCE NAME (IF APPLICABLE): _____ Phone: _____ ID/Policy #: _____ Group #: _____

3 PATIENT AUTHORIZATION

I authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions, and health insurance to Patient Services and Solutions, Inc. and its affiliates, contractors, and agents, including its third-party patient support program service provider (collectively "Teva") for the purposes described below. I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field-based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research, and Program-related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence-related communications, reminders, and support, for which the third-party service provider may receive financial remuneration from the manufacturer of your medication. I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, Teva Shared Solutions, P.O. Box 4280, Gaithersburg, MD, 20885-4280, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE: _____ Date: _____

If signed by someone other than the patient, complete the following information: Name: _____ Relationship/legal authority to sign on patient behalf: _____

☐ By checking this box, I authorize Teva Neuroscience, Inc. ("Teva"), its affiliates, and the companies working with Teva to contact me by direct mail, email, telephone (including autodialed and/or prerecorded calls and/or messages), and electronic messages for marketing and promotional purposes, to conduct market research or surveys, and to use my information to develop future products, services, and programs. I understand that I may choose to no longer receive further communications from Teva by following the unsubscribe instructions on the communication. Opting in to these communications is not a requirement or a condition of purchase. Terms and conditions apply: www.pssmobileterms.com.

SECTIONS 4–8 MUST BE COMPLETED BY PRESCRIBER

4 PREFERRED PHARMACY

Preferred Pharmacy*: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Check here if preferred pharmacy is site of UZEDY administration

*Prescription will be triaged to preferred pharmacy unless otherwise dictated by insurance mandate and/or patient preference.

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SECTIONS 4-8 MUST BE COMPLETED BY PRESCRIBER

5 PRESCRIPTION FOR UZEDY

REQUIRED FOR PROCESSING

IMPORTANT NOTICE: Please attach all prescriptions on Official State Prescription form if mandated by individual state laws. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, or hard copy prescription, etc.

☐ If supplying prescription via Escript, please check here

PATIENT NAME: _____ DOB (MM/DD/YYYY): _____

ICD-10 Code:

☐ F20.0 Paranoid schizophrenia ☐ F20.1 Disorganized schizophrenia ☐ F20.2 Catatonic schizophrenia ☐ F20.3 Undifferentiated schizophrenia

☐ F20.5 Residual schizophrenia ☐ F20.89 Other schizophrenia ☐ F20.9 Unspecified schizophrenia ☐ Other: _____

UZEDY DOSAGE STRENGTH AND INTERVAL

Once monthly:

☐ 50 mg/0.14 mL ☐ 75 mg/0.21 mL

☐ 100 mg/0.28 mL ☐ 125 mg/0.35 mL

Once every 2 months:

☐ 100 mg/0.28 mL ☐ 150 mg/0.42 mL

☐ 200 mg/0.56 mL ☐ 250 mg/0.7 mL

Sig/Directions: _____

Quantity: _____ Refills #: _____

6 PRESCRIBER

Prescriber Name: _____ Title: ☐ MD ☐ DO ☐ NP ☐ PA State License #: _____

Name of Facility/Provider Office: _____ Prescriber NPI #: _____

REQUIRED FOR PROCESSING

Address: _____ City: _____ State: _____ Zip: _____

Type of setting:

☐ Hospital Inpatient Center ☐ (Hospital) Outpatient (Care) Center ☐ Provider office ☐ Community Mental Health Center (CMHC), (Community) Behavioral/Mental Health Center/Clinic (CBHC, B/MHC, etc.)

Nurse/Office Contact: _____ Nurse/Office Phone: _____ Nurse/Office Fax: _____

7 PRESCRIBER ATTESTATION

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Teva Neuroscience, Inc., and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. Any medications supplied by Teva as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement and any administration charges will be consistent with my practice's standard policies for treatment of and charges to financially needy patients. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Teva may change or cancel this program at any time; Teva also reserves the right to terminate my patient's enrollment at any time. By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Teva and its employees or agents for purposes relating to Teva's patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for the drug specified in this enrollment form. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive, any benefit for prescribing a specific drug.

Signature and date required before submission.

My signature below indicates that I have read, understand, and agree to the Prescriber Attestation.

PRESCRIBER SIGNATURE: ***Prescriber signature must be the same as Prescriber name. Stamped/computer-generated signatures are NOT permitted – ink signature only.***

REQUIRED FOR PROCESSING

_____ _____

DISPENSE AS WRITTEN DATE

8 SITE OF CARE

Has patient had an initial UZEDY treatment? ☐ Yes ☐ No

If yes, date of initial UZEDY administration: _____ Date of next UZEDY administration: _____

Will the site of care for UZEDY administration be the same as the Prescriber address in section 6? ☐ Yes ☐ No

If no, complete SITE OF CARE section below, or ☐ Check here to request assistance identifying a site of care for the patient

SITE OF CARE:

ONLY complete if site of care is different from Prescriber address

Name of Facility/Provider Office: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Type of setting:

☐ Hospital Inpatient Center ☐ (Hospital) Outpatient (Care) Center ☐ Provider office ☐ Community Mental Health Center (CMHC), (Community) Behavioral/Mental Health Center/Clinic (CBHC, B/MHC, etc.)

Complete all fields to avoid processing delays. Print and fax completed form, including a front/back copy of the patient's insurance cards(s) and pharmacy benefit card, to 1-877-228-4190.