Sunovion Support®
Prescription Assistance Program ("Program")

To apply for help in affording your **Aptiom®** (eslicarbazepine acetate) tablets prescription, please mail completed application to:

Sunovion Support® Prescription Assistance Program
PO Box 220285, Charlotte, NC 28222-0285

or **fax: (877) 850-0821**

Remember to include both your signature and that of your doctors, proof of income and the patient's prescription. If you have any questions or need help filling out this form, please contact us at (877)850-0819 or visit **www.sunovionsupport.com**.

Patient Information

Name: _____

Date of Birth: _____ Phone: (____) _____ Gender: ☐ M ☐ F

Mailing Address: _____

City: _____ State: _____ Zip: _____

Is the patient a US resident (includes Puerto Rico)? ☐ YES ☐ NO

Is the patient 18 years of age or older? ☐ YES ☐ NO If No, please complete the Legal Guardian Section below

Legal Guardian information when patient is under 18 years or otherwise has a court-appointed legal guardian:

Parent/Legal Guardian(s) Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Household Income Information (if patient is under the age of 18, please complete information as the parent/legal guardian)

1. Number of people in household: ____ (include yourself, your spouse and any dependents)
2. What is total **GROSS ANNUAL** household income (including Social Security, Disability, Veterans, Wages, pension benefits, etc.)? $ _____
3. Did the parent/legal guardian file a Federal Income Tax Return for previous calendar year? ☐ YES ☐ NO

Please provide us with one of the following items to show total gross annual household income:

- Current paycheck stubs, proof of Social Security Income, 1099 or W-2 forms for all members of household
- Federal Tax Return (form 1040 or 1040EZ) for prior tax year

If the patient has not filed a Federal Income Tax Return, visit **www.IRS.gov** to request a free Verification of Non-Filing. Click on "Order a Transcript" or call (800) 908-9946. Use Form 4506-T and check box 7 to request verification of non-filing.

Sunovion Support®
Prescription Assistance Program

Patient's Insurance Information

1. Is the patient enrolled in Medicare/Medicaid? ☐ YES ☐ NO

2. Does the patient have prescription drug coverage through any other benefit program that helps pay for prescription medicine, such as private insurance or VA or military benefits, including Medicare Part D? ☐ YES ☐ NO
AA

If yes: please describe:

Insurance Information (Include Medicare/Medicaid information, if applicable)

Insurance Company Name: _____ Policy ID #: _____ Group #: _____

Phone #: _____ Subscriber Name: _____ Date of Birth: _____

Prescription Card #: _____ Carrier: _____ Rx Card Phone#: _____

From the Health Care Professional (to be completed by the doctor who is prescribing the medicine)

Health Care Professional: _____

Site contact: _____ State License #: _____

Facility Name: _____ Tax ID #: _____

Phone: (____) _____ Fax: (____) _____

Street address: _____

City: _____ State: _____ Zip: _____

Prescription Information: Aptiom® (eslicarbazepine acetate) tablets

Please see Important Safety Information, on page 5. For more information please see the APTIOM Medication Guide (http://www.aptiom.com/Aptiom-Medication-Guide.pdf) and Full Prescribing Information (http://www.aptiom.com/Aptiom-Prescribing-Information.pdf).

Dosage: ☐ 200mg/day ☐ 400mg/day ☐ 600mg/day ☐ 800mg/day ☐ 1200mg/day ☐ 1600mg/day

Day Supply: ☐ 30 Days

Method of delivery:

☐ Patient will pick up prescription at retail pharmacy (will receive 30 day supply/ per fill only)

Number of Refills (max 11): _____

If there is a change in prescription or diagnosis of patient, Sunovion Support needs to be notified in writing.

ICD-10 Code (required information)

- ☐ G40.0 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset
  - ☐ G40.00 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable
    - ☐ G40.001 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, with status epilepticus
    - ☐ G40.009 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus
  - ☐ G40.01 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable
    - ☐ G40.011 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
    - ☐ G40.019 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
- ☐ G40.1 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures
  - ☐ G40.10 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable
    - ☐ G40.101 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, with status epilepticus
    - ☐ G40.109 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
  - ☐ G40.11 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable
    - ☐ G40.111 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
    - ☐ G40.119 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures intractable, without status epilepticus
- ☐ G40.2 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
  - ☐ G40.20 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable
    - ☐ G40.201 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus
    - ☐ G40.209 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
  - ☐ G40.21 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable
    - ☐ G40.211 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
    - ☐ G40.219 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
- ☐ G40.8 Other epilepsy and recurrent seizures
  - ☐ G40.80 Other epilepsy
    - ☐ G40.801 Other epilepsy, not intractable, with status epilepticus
    - ☐ G40.802 Other epilepsy, not intractable, without status epilepticus
    - ☐ G40.803 Other epilepsy, intractable, with status epilepticus
    - ☐ G40.804 Other epilepsy, intractable, without status epilepticus
  - ☐ G40.89 Other seizures
- ☐ G40.9 Epilepsy, unspecified
  - ☐ G40.90 Epilepsy, unspecified, not intractable
    - ☐ G40.901 Epilepsy, unspecified, not intractable, with status epilepticus
    - ☐ G40.909 Epilepsy, unspecified, not intractable, without status epilepticus
  - ☐ G40.91 Epilepsy, unspecified, intractable
    - ☐ G40.911 Epilepsy, unspecified, intractable, with status epilepticus
    - ☐ G40.919 Epilepsy, unspecified, intractable, without status epilepticus

Your Consent is Required to Process Application

I acknowledge and agree that the above information is complete and accurate. I attest that I have no prescription insurance coverage, including Medicaid, Medicare or other public or private program, and I have insufficient financial resources to pay for the prescribed product. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient's Signature: _____ Date: _____

If you are unable to sign or are a minor, under the age of 18, a parent or legal guardian must sign.

Representative's Name: _____

Representative's Signature: _____ Date: _____

Describe relationship to Applicant: _____

Health Care Professional Signature is Required to Process Application for the Sunovion Support Prescription Assistance Program

My signature below certifies that the person named in this form is my patient and medication received from the Program is only for that patient's use as indicated by the US Food and Drug Administration, and the information provided, to my knowledge, is accurate. I understand this Program is only for APTIOM and it will not be offered for sale, trade, or barter. I agree that I will not submit any claim for reimbursement concerning the Product to Medicare, Medicaid, or any other third party, or return such Product for credit. I also agree that the Program has the right at any time to contact my patient, to modify or terminate the Program, and to recall or discontinue Product without notice. To the best of my knowledge, my patient does not have prescription drug insurance coverage (including Medicare, Medicaid, county funded, or other public programs) for the product being requested.

Letter of Affiliation: I certify that I am (a) affiliated with the entity(ies) and location(s) identified on this application, (b) will be responsible in all respects for the receipt and accountability of the pharmaceutical products shipped to this entity at such location, and (c) will immediately notify the Program if either of the foregoing statements is no longer true.

Please indicate affiliated shipping address for Health Care professional where the medication will be shipped:

Health Care Professional Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Health Care Professional Signature: _____ Date: _____

California residents, please visit www.sunovion.com/CAprivacynotice for information about the collection and use of your personal information.

Important Safety Information and Indication for APTIOM®

Indication:
Aptiom® (eslicarbazepine acetate) is a prescription medicine to treat partial-onset seizures in patients 4 years of age and older.

Important Safety Information:
It is not known if APTIOM is safe and effective in children under 4 years of age.

Do not take APTIOM if you are allergic to eslicarbazepine acetate, any of the other ingredients in APTIOM, or oxcarbazepine.

Suicidal behavior and ideation: Antiepileptic drugs, including APTIOM, may cause suicidal thoughts or actions in a very small number of people, about 1 in 500. Call your doctor right away if you have any of the following symptoms, especially if they are new, worse, or worry you: thoughts about suicide or dying; attempting to commit suicide; new or worse depression, anxiety, or irritability; feeling agitated or restless; panic attacks; trouble sleeping (insomnia); acting aggressive; being angry or violent; acting on dangerous impulses; an extreme increase in activity and talking (mania); or other unusual changes in behavior or mood.

Allergic reactions: APTIOM may cause serious skin rash or other serious allergic reactions that may affect organs or other parts of your body like the liver or blood cells. You may or may not have a rash with these types of reactions. Call your doctor right away if you experience any of the following symptoms: swelling of the face, eyes, lips, or tongue; trouble swallowing or breathing; hives; fever, swollen glands, or sore throat that do not go away or come and go; painful sores in the mouth or around your eyes; yellowing of the skin or eyes; unusual bruising or bleeding; severe fatigue or weakness; severe muscle pain; or frequent infections or infections that do not go away.

Low salt (sodium) levels in the blood: APTIOM may cause the level of sodium in your blood to be low. Symptoms may include nausea, tiredness, lack of energy, irritability, confusion, muscle weakness or muscle spasms, or more frequent or more severe seizures. Some medicines can also cause low sodium in your blood. Be sure to tell your health care provider about all the other medicines that you are taking.

Nervous system problems: APTIOM may cause problems that can affect your nervous system, including dizziness, sleepiness, vision problems, trouble concentrating, and difficulties with coordination and balance. APTIOM may slow your thinking or motor skills. Do not drive or operate heavy machinery until you know how APTIOM affects you.

Liver problems: APTIOM may cause problems that can affect your liver. Symptoms of liver problems include yellowing of your skin or the whites of your eyes, nausea or vomiting, loss of appetite, stomach pain, or dark urine.

Most common adverse reactions: The most common side effects in adult patients taking APTIOM include dizziness, sleepiness, nausea, headache, double vision, vomiting, feeling tired, problems with coordination, blurred vision, and shakiness.

Drug interactions: Tell your health care provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements. Taking APTIOM with certain other medicines may cause side effects or affect how well they work. **Do not start or stop other medicines without talking to your health care provider.** Especially tell your health care provider if you take oxcarbazepine, carbamazepine, phenobarbital, phenytoin, primidone, clobazam, omeprazole, simvastatin, rosuvastatin, or birth control medicine.

Discontinuation: Do not stop taking APTIOM without first talking to your health care provider. Stopping APTIOM suddenly can cause serious problems.

Pregnancy and lactation: APTIOM may cause your birth control medicine to be less effective. Talk to your health care provider about the best birth control method to use. APTIOM may harm your unborn baby. APTIOM passes into breast milk. Tell your health care provider if you are pregnant or plan to become pregnant, or are breastfeeding or plan to breastfeed. You and your health care provider will decide if you should take APTIOM. If you become pregnant while taking APTIOM, talk to your health care provider about registering with the North American Antiepileptic Drug (NAAED) Pregnancy Registry. The purpose of this registry is to collect information about the safety of antiepileptic medicine during pregnancy. You can enroll in this registry by calling 1-888-233-2334.

Get medical help right away if you have any of the symptoms listed above.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call (800) FDA-1088.

For more information, please see the APTIOM Medication Guide (http://www.aptiom.com/Aptiom-Medication-Guide.pdf) and Full Prescribing Information (http://www.aptiom.com/Aptiom-Prescribing-Information.pdf).

Sunovion Support® Prescription Assistance Program © 2020 Sunovion Pharmaceuticals Inc.
PO Box 220285 | Charlotte, NC 28222-0285 | Phone (877) 850-0819 | Fax (877) 850-0821

Authorization and Consent to Share and Disclose Health Information with the Sunovion Support Prescription Assistance Program ("Program")

Please read and sign this form so that you or the person for whom you are assisting may be able to participate in the Program.
Please note "I" is defined as the potential Participant.

- I acknowledge and agree that all the information I provide in connection with my application to the Program will be used to decide if I qualify for the Program.
- By signing below, I verify that the information on my application, including a copy of my proof of income documentation, is complete and accurate.
- I do not have any other coverage for prescription medications, including Medicaid, Medicare, or any public or private assistance programs or any other prescription insurance.
- I understand that any changes to my financial, prescription drug coverage, diagnosis, or insurance information may affect whether I am able to continue to participate in the Program. I agree to contact the Program to inform them of any changes to my income, prescription drug coverage, diagnosis, or insurance information.
- I allow my health care provider(s), my pharmacy(ies), and my health plan or insurers, to give medical information relating to my use or need for product(s) provided under the Program to The Lash Group, Inc. The Lash Group runs the Program on behalf of Sunovion Pharmaceuticals Inc. My medical information can include spoken or written facts about my health and payment benefits. It can include copies of records from my health care provider, pharmacy, or health plan about my health or health care.
- People who work for The Lash Group and the Program may see my information, but they may use it only to help me get assistance to receive my Sunovion medication, to determine whether I qualify for the Program, to operate the Program, or as otherwise required or permitted by law.
- I allow The Lash Group and the Program the right to verify and to evaluate any financial documentation, insurance information, and medical records submitted to the Program to determine if I qualify for the Program and to operate the Program.
- I understand that The Lash Group and the Program have the right to contact me directly to confirm receipt of medications [or to obtain my feedback about the Program] and that the Program can revise, change, or terminate the Program at any time.
- I understand that I may cancel my permission and withdraw from this Program at any time.
- I understand that if I cancel my permission I can tell my health care provider, my pharmacy, and my insurer in writing that I do not want them to share any more information with The Lash Group and the Program, but it will not change any actions they took before I told them and it will terminate my participation in the Program.
- This authorization and consent will last for up to12 months.
- I know that I have a right to see or copy the information my health care providers, my pharmacy, or insurers have given to The Lash Group and the Program.
- I understand that I am free at any time to switch my health care provider and it will not affect eligibility for financial assistance. This Program is offered to me regardless of any health care provider or pharmacy I use.
- I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers, pharmacies, or insurers treat me. If I refuse to sign this form, I know that this means I will not be eligible to participate in the Program.
- I understand that signature of a legal guardian or parent is required for all minor applicants and those patients who are unable to sign.

Applicant Signature: _____ Date: _____

Applicant Name: _____

If you are unable to sign a legal guardian must sign.

Representative's Name: _____ Date: _____

Representative's Signature: _____ Describe relationship to Applicant: _____

If someone helped you with the application and you want them to answer questions for you, please give us their name and phone number:

Name: _____ Phone: (____) _____

PO Box 220285 | Charlotte, NC 28222-0285 | Phone (877) 850-0819 | Fax (877) 850-0821