Sunovion Support®

PRESCRIPTION ASSISTANCE PROGRAM

sunovion
Innovation today, healthier tomorrows

To apply for help in affording your **LATUDA®** (lurasidone HCl) prescription, please see Important Safety Information, including **Boxed Warning** on pages 4 and 5 and enclosed full Prescribing Information.

Please mail completed application to:

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

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

Remember to include both your signature and that of your prescribing doctor, 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 Patient is a minor, under the age of 18 years, or has a legal guardian please complete this section:

Parents/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 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 patient/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 Income Tax Return (IRS 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 IRS Form 4506-T and check box 7 to request verification of non-filing.

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

If yes: please describe: _____

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

*Healthcare Professional: _____

HCCE permit # (required in state of FL only) _____

Site contact: _____ State License #: _____

Facility Name: _____

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

Street address: _____

City: _____ State: _____ Zip: _____

Prescription Information: Latuda (lurasidone HCl)

Please see Important Safety Information, including **Boxed Warning** on pages 4 and 5 and enclosed full Prescribing Information.

Dosage: 20mg/day 40mg/day 60mg/day 80mg/day 120mg/day 160mg/day

Day Supply: 30 Days ☐ 60 Days ☐ 90 days

Method of delivery:

☐ Prescription to be shipped directly to healthcare professional's address provided on page 3

☐ 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)

- ☐ F20.0 Paranoid schizophrenia
- ☐ F20.1 Disorganized schizophrenia
- ☐ F20.3 Undifferentiated schizophrenia
- ☐ F20.5 Residual schizophrenia
- ☐ F20.89 Other schizophrenia
- ☐ F20.9 Schizophrenia, unspecified
- ☐ F31.30 Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
- ☐ F31.31 Bipolar disorder, current episode depressed, mild
- ☐ F31.32 Bipolar disorder, current episode depressed, moderate
- ☐ F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features

* If Healthcare Provider is not an MD please provide required supporting documentation authorizing prescribing of and receiving of prescription medication. Please visit the website www. NABP.net if you have questions as to what your state may require for you to receive medication shipped directly to you. All required documentation must be received to ship medication.

Your Consent is Required to Process Application for the Sunovion Support Prescription Assistance Program

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 also sign.

Representative's Name: _____

Representative's Signature: _____ Date: _____

Describe relationship to Applicant: _____

Healthcare 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 LATUDA 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 Medicaid, Medicare, 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 Medicaid, Medicare, or other public or private programs) for the product being requested.

Letter of Affiliation: I certify that I (a) am 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 healthcare professional to whom the medication will be shipped:

Healthcare Professional Name: _____

Street Address: _____

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

Healthcare Professional Signature: _____ Date: _____

Important Safety Information and indications for LATUDA

INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS; AND SUICIDAL THOUGHTS AND BEHAVIORS

Elderly people with dementia-related psychosis (having lost touch with reality due to confusion and memory loss) treated with this type of medicine are at an increased risk of death compared to patients receiving placebo (sugar pill). LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Antidepressant medicines may increase suicidal thoughts or behaviors in some children, teenagers, and young adults within the first few months of treatment. Depression and other serious mental illnesses are themselves associated with an increase in the risk of suicide. Patients on antidepressants and their families or caregivers should watch for new or worsening depression symptoms, especially sudden changes in mood, behaviors, thoughts, or feelings. This is very important when an antidepressant medicine is started or when the dose is changed. Report any change in these symptoms immediately to the doctor. LATUDA is not approved for use in pediatric patients with depression.

LATUDA can cause serious side effects, including stroke that can lead to death, which can happen in elderly people with dementia who take medicines like LATUDA.

Neuroleptic malignant syndrome (NMS) is a rare but very serious condition that can happen in people who take antipsychotic medicines, including LATUDA. NMS can cause death and must be treated in a hospital. Call your health care provider right away if you become severely ill and have some or all of these symptoms: high fever, excessive sweating, rigid muscles, confusion, or changes in your breathing, heartbeat or blood pressure.

Tardive dyskinesia (TD) is a serious and sometimes permanent side effect reported with LATUDA and similar medicines. Tell your doctor about any movements you cannot control in your face, tongue, or other body parts, as they may be signs of TD. TD may not go away, even if you stop taking LATUDA. TD may also start after you stop taking LATUDA.

Increases in blood sugar can happen in some people who take LATUDA. Extremely high blood sugar can lead to coma or death. If you have diabetes or risk factors for diabetes (such as being overweight or a family history of diabetes), your health care provider should check your blood sugar before you start LATUDA and during therapy. Call your health care provider if you have any of these symptoms of high blood sugar (hyperglycemia) while taking LATUDA: feel very thirsty, need to urinate more than usual, feel very hungry, feel weak or tired, feel sick to your stomach, feel confused, or your breath smells fruity.

Increases in triglycerides and LDL (bad) cholesterol and decreases in HDL (good) cholesterol have been reported with LATUDA. You may not have any symptoms, so your health care provider may decide to check your cholesterol and triglycerides during your treatment with LATUDA.

Some patients may gain weight while taking LATUDA. Your doctor should check your weight regularly.

Tell your doctor if you experience any of these:

- feeling dizzy or light-headed upon standing
- decreases in white blood cells (which can be fatal)
- trouble swallowing

LATUDA and medicines like it may raise the level of prolactin. Tell your health care provider if you experience a lack of menstrual periods, leaking or enlarged breasts, or impotence.
Tell your health care provider if you have a seizure disorder, have had seizures in the past, or have conditions that increase your risk for seizures.

Tell your health care provider if you experience prolonged, abnormal muscle spasms or contractions, which may be a sign of a condition called dystonia.

LATUDA can affect your judgment, thinking, and motor skills. You should not drive or operate hazardous machinery until you know how LATUDA affects you.

LATUDA may make you more sensitive to heat. You may have trouble cooling off. Be careful when exercising or when doing things likely to cause dehydration or make you warm.

Avoid eating grapefruit or drinking grapefruit juice while you take LATUDA since these can affect the amount of LATUDA in the blood.

Tell your health care provider about all prescription and over-the-counter medicines you are taking or plan to take, since there are some risks for drug interactions with LATUDA. Tell your health care provider if you are allergic to any of the ingredients of LATUDA or take certain medications called CYP3A4 inhibitors or inducers. Ask your health care provider if you are not sure if you are taking any of these medications.

Avoid drinking alcohol while taking LATUDA.

Tell your health care provider if you are pregnant or if you are planning to get pregnant. Avoid breastfeeding while taking LATUDA.

The most common side effects of LATUDA include sleepiness or drowsiness; restlessness or feeling like you need to move around (akathisia); difficulty moving, slow movements, muscle stiffness, or tremor; runny nose/nasal inflammation, and nausea.

These are not all the possible side effects of LATUDA. For more information, ask your health care provider or pharmacist.

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

INDICATIONS
LATUDA is used to treat patients with:

- Depressive episodes in bipolar I disorder (bipolar depression) when used alone or with lithium or valproate in adults
- Schizophrenia in adults and adolescents 13 to 17 years of age

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 or are a minor, under the age of 18, a parent or legal guardian must also 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: (____) _____

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