TRANSITION OF CARE FORM (TOCF)

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.

USE THIS FORM TO ENROLL PATIENTS IN SHARED SOLUTIONS TO SEEK HELP WITH TRANSITION OF CARE AND WHEN PRESCRIBING UZEDY.

1 SITE OF CARE

REQUIRED FOR PROCESSING

FROM

DISCHARGING INPATIENT SITE INFORMATION:

Site Name:

Address:

City: State: Zip:

Site Contact Name: Contact Phone:

Prescriber Name: NPI#:

Date of Discharge:

TO

NEXT SITE OF CARE INFORMATION:

Site Name:

Address:

City: State: Zip:

Site Contact Name: Contact Phone:

Site Fax: Date of Appointment:

Prescriber Name: NPI#:

Type of setting:

- ☐ (Hospital) Outpatient (Care) Center
- ☐ Community/Behavioral Mental Health Center (CMHC/BMHC)
- ☐ Provider office
- ☐ Other: _____

2 PATIENT INFORMATION

REQUIRED FOR PROCESSING

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:

3 PATIENT AUTHORIZATION

REQUIRED FOR PROCESSING

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, 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.

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Patient Name: _____ **DOB (MM/DD/YYYY):** _____

4 DIAGNOSIS AND HISTORY

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: _____

Date of last UZEDY administration:

_____

☐ Started on UZEDY in the inpatient/ acute care setting

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

5 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 #: _____

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

6 PREFERRED PHARMACY

Preferred Pharmacy: _____ Phone: _____ Fax: _____

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

☐ **Already prescribed UZEDY to above pharmacy on** _____

Date

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