

Patient Assistance Program Patient Enrollment Form

Instructions for Enrollment

Intra-Cellular Therapies, Inc. (ITCI), now part of Johnson & Johnson (J&J) believes that access and affordability challenges shouldn't stand in the way of patients and their medicines. Medicines from Intra-Cellular Therapies may be provided at no cost to eligible patients who are uninsured or have inadequate coverage through commercial, employer group, or government insurance coverage and are not supported by other Intra-Cellular Therapies offerings.

Enrollment Checklist

- Complete all sections and sign on page 2
- Review pages 4-7, which contain the Patient Authorization Form, Terms of Participation, and Terms & Conditions, in their entirety. Please certify that you have read, understand, and agree by signing on page 2
- Ask your Healthcare Provider to complete and sign page 3
- Gather any required supporting documents to determine what you need to include (if any)

Supporting Documents

Please provide the following information:

- Insurance Information: Copies of the front and back of all insurance card(s) (eg, medical, pharmacy, etc, if you did not complete section 2 on page 2)
- Medicare Part D Patients Only: Submit a report from your pharmacy **OR** an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year
- Proof of Income: A copy of your most recent 1040 or 1040-SR Federal tax return
- For Puerto Rico Only: Please include financial documentation support with application submission. Acceptable forms: Income Tax Return (Form 482), Form AS 6088.1 – Returns Filing Certification, Form SSA-1099 – Social Security Benefits

Complete this Patient Assistance Enrollment Form to the best of your ability, including the supporting documents, and fax to: 888-481-4838. Any required information you did not provide with your initial submission will cause delays in processing your application. For assistance on how to complete the form or questions about the program, call **888-481-4824**, Monday through Friday, 9:00 AM to 6:00 PM ET.

Please see full Prescribing Information, including Boxed WARNINGS at CAPLYTA.com

Patient Assistance Enrollment Form

The information you provide will be used by Intra-Cellular Therapies and our service providers to determine your eligibility for and enroll you in the Intra-Cellular Therapies Patient Assistance Program. You may withdraw your request for these services by calling 888-481-4824. Our **Privacy Policy** further governs the use of the information you provide.

To Be Completed by Patient

Fields marked with an (*) are required

1. PATIENT INFORMATION

*First Name: _____ *Last Name: _____ *Primary Phone: _____

Email: _____ *Date of Birth (mm/dd/yyyy): _____ *Sex: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: _____ *ZIP Code: _____

*Product Name: _____

This is the address that all self-administered medicine will be shipped to. For a change of address, please contact 888-481-4824 and share the information with your Healthcare Provider.

2. INSURANCE INFORMATION (Complete for all available insurance and submit copies of front and back of all insurance cards.)

I have no insurance and have checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance. If you were previously enrolled in a patient assistance program, please provide your patient ID #: _____

Primary Prescription Insurance (PPI): _____ PPI Prescription Card BIN #: _____ PPI Phone: _____

PPI Cardholder Name (First, MI, Last): _____ PPI Cardholder Date of Birth: _____

PPI Relationship to Cardholder: _____

PPI Policy #: _____ PPI Group #: _____

Primary Medical Insurance (PMI): _____ PMI Phone: _____

PMI Cardholder Name (First, MI, Last): _____ PMI Cardholder Date of Birth: _____

PMI Relationship to Cardholder: _____

PMI Policy #: _____ PMI Group #: _____

Secondary Medical Insurance (SMI): _____ SMI Phone: _____

SMI Cardholder Name (First, MI, Last): _____

SMI Relationship to Cardholder: _____

SMI Policy #: _____ SMI Group #: _____

*Cardholder Employer Name: _____ *Cardholder Employer Phone: _____

*Cardholder Employer Address: _____

*Cardholder Employer City: _____ *Cardholder Employer State: _____ *Cardholder Employer ZIP Code: _____

3. FINANCIAL INFORMATION

***Total Gross Annual Income**
Entire household: \$ _____

***Household Size**
Including yourself, the number of people who live in your home and are dependent on your household income: _____

(A credit check is required to confirm you meet the income eligibility. This will not impact your credit score.)

4. TERMS OF PARTICIPATION AND TERMS & CONDITIONS CONSENT (Please review Terms & Conditions and Terms of Participation on pages 6-7.)

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the Terms & Conditions and Terms of Participation on pages 6-7. I understand that I am providing written instructions to ITCI under the Fair Credit Reporting Act authorizing ITCI to perform a credit check in order to obtain information from my credit profile or other information from Experian Health. I understand this will not impact my credit score. I give consent to ITCI to obtain such information solely to determine if my income meets eligibility standards of the patient assistance program.

*Print Patient Name: _____

*Patient or Legally Authorized Representative[†] sign here: _____ *Date: _____

[†]A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.

5. PATIENT AUTHORIZATION FORM CONSENT (Please review Patient Authorization Form on pages 4-5.)

By signing below, I certify that I have read, understand, and agree to the Intra-Cellular Therapies patient support program patient authorization form on pages 4-5.

*Print Patient Name: _____

*Patient or Legally Authorized Representative[†] sign here: _____ *Date: _____

[†]A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.

*Describe relationship to patient and authority to make medical decisions for patient: _____

Patient Assistance Enrollment Form

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To Be Completed by Provider

Fields marked with an (*) are required

1. PRESCRIPTION: CAPLYTA® (lumateperone) Capsules

*Patient First Name: _____ *Patient Last Name: _____ *Patient Primary Phone: _____

*Patient Address Line 1: _____ Patient Address Line 2: _____

*Patient City: _____ *Patient State: _____ *Patient ZIP Code: _____

*Patient Date of Birth (mm/dd/yyyy): _____ *Patient Sex: _____

ICD Code: _____ *Strength: 42 mg 21 mg 10.5 mg

*Sig: _____

*Quantity: _____ *Day Supply: _____ *Number of Refills (maximum 11): _____ *Need by Date: _____

Additional Notes: _____

*Patient Allergies: _____ or none

*List of Patient's Current Medicines: _____ or none

*Ship to Location: Patient Home (same as above) Prescriber Office (same as section 2. HCP Information)

2. HCP INFORMATION *(The address you provide here will be used if Ship to Prescriber Office is selected above.)*

*HCP First Name: _____ *HCP Last Name: _____ *HCP Site Name: _____

HCP Site Contact: _____ HCP Business Hours: _____

*HCP Address Line 1: _____ HCP Address Line 2: _____

*HCP City: _____ *HCP State: _____ *HCP ZIP Code: _____

*HCP Phone: _____ *HCP Fax: _____ HCP Email: _____

*HCP Tax ID #: _____ *HCP NPI #: _____

HCP State License #: _____ HCP Expiration (mm/yyyy): _____ HCP DEA #: _____

HCP Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)*: _____

If you are aware of an Assistance Diversion Program (ADP) being part of the patient's plan design, please provide the details below:

ADP Name: _____ ADP Address: _____

ADP City: _____ ADP State: _____ ADP ZIP Code: _____

ADP Phone: _____ ADP Fax: _____

3. HCP AUTHORIZATION

The prescriber is responsible for ensuring the prescription complies with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, or fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.

My signature below indicates that I have read, understand, and agree to the Intra-Cellular Therapies policy and the terms of Program participation.

**HCP SIGN
& DATE:**

*Healthcare Provider Signature _____ *HCP Authorization Date (mm/dd/yyyy): _____

HCP=healthcare provider.

Patient support program patient authorization form

Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Intra-Cellular Therapies.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share and reshare my Protected Health Information, as described on this Form.

My Protected Health Information includes information related to: my medical condition, treatment, prescriptions, and health insurance coverage.

My Healthcare Providers may include: physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices.

I give permission to these people or groups to receive and use my Protected Health Information (collectively "ITCI"):

- Intra-Cellular Therapies, its agents and representatives
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping ITCI run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from ITCI's support programs

My Protected Health Information may be shared by ITCI with these people and groups: my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from ITCI's patient support programs.

ITCI and the other groups on this Form may share information about me in 2 ways: as permitted on this Form, and if any information that identifies me is removed from what has been shared.

Section 2 How can giving permission help with patient support programs and access?

I give permission to ITCI to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to ITCI's patient support programs. This includes in-home services
- Manage ITCI's patient support programs
- Give me resources and information related to my ITCI medicine in connection with ITCI's patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my ITCI medicine
- Inform my Healthcare Provider that I am enrolled in ITCI's patient support programs
- Help verify and coordinate coverage for ITCI medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help ITCI evaluate, create, and improve their patient support services and products for patients prescribed ITCI medicines
- Share information from ITCI's patient support programs that may be useful for my care

I understand that:

ITCI will use reasonable efforts to keep my information private. But, once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from ITCI's patient support programs.

The following groups may be paid by ITCI for their services and data, including Protected Health Information:

- Pharmacies that dispense and ship my medicine
- Service providers for ITCI's patient support programs

This Form will remain in effect 5 years from the date I signed, except if:

- State law requires a shorter time or
- I am no longer in any patient support program from ITCI

MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4) this authorization expires one year from the date of signature.

Information collected before that date may continue to be used for the purposes noted in this Form:

- I may cancel the permissions given by this Form at any time by letting ITCI know in writing at:
P.O. Box 5554 Louisville, KY 40255
- I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with ITCI
- If I cancel my permission, it will not affect how ITCI uses and shares my Protected Health Information received by ITCI before my cancellation
- I may request a copy of this Form

Your agreement to this patient support program patient authorization form is captured on page 2 section 5.

Terms of Participation

I understand that ITCI and third parties associated with administrating the Program on behalf of ITCI (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time
- May request and obtain information about my or my family's income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf or third-party sources
- May request that I re-verify my eligibility to receive medicines under the Program

I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from Intra-Cellular Therapies, Inc. (ITCI) and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider, or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to ITCI to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Intra-Cellular Therapies Patient Assistance Program within thirty (30) days if there is any change in my income or health insurance coverage. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Intra-Cellular Therapies Patient Assistance Program to any person or entity, including my Medicare Part D plan
- I will not seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program

Terms & Conditions

You may be eligible to receive your medicine(s) from Intra-Cellular Therapies at no cost for up to one year if you have been prescribed a medicine from ITCI, have a financial hardship and have exhausted all other affordability options.

You must meet the eligibility and income requirements to qualify for the Intra-Cellular Therapies Patient Assistance Program.

You are not eligible for medicine from ITCI at no cost if your health insurance will cover the cost of your prescribed medicine from ITCI if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medicines from free product programs instead of covering such medicines directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by ITCI to make sure that help is available for patients with no safety net in place. Your insurer must submit a Patient Eligibility Certification form to confirm that your drug coverage is not subject to an Assistance Diversion Program.

Intra-Cellular Therapies Patient Assistance Program does not replace products that were administered or dispensed to eligible and enrolled patients from provider supply or provider-affiliated pharmacy supply.

You may not seek payment for the value of medicines from ITCI received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Before you enroll in the patient assistance program, it is important you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, financial information, and/or other information, including information related to your prescription medicine insurance and treatment. This information will be used by Intra-Cellular Therapies and its service providers to determine your eligibility for, enroll you in, and administer the program. The use of your information will be governed by our [Privacy Policy](#).

If your income is equal to or less than 150% of the Federal Poverty Level (FPL), you will need to demonstrate that you are not eligible for the Low-Income Subsidy (LIS).

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States, Puerto Rico, and the US Virgin Islands, which includes St. Thomas, St. John, and St. Croix. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

You may end your participation in the program at any time by calling 888-481-4824, Monday through Friday, 9:00 AM to 6:00 PM ET.

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