KEPPRA XR® (levetiracetam) extended-release tablets

ucb

VIMPAT® (lacosamide) C

Patient Assistance Program

Attending Physician Instructions

Please complete all the required information below. In the space provided, indicate the patient's diagnosis and/or diagnostic code(s). Gather all information (including prescription and most current proof of income) **and please ensure that all documents are signed and dated.** Mail the completed application to the UCB Patient Assistance Program at the address below.

Please select one of the following drug strengths and provide frequency. Attach your prescription to this form.

CHECK ONE STRENGTH ONLY

- ☐ Vimpat 50mg Tablets — Frequency* _____
- ☐ Vimpat 100mg Tablets — Frequency* _____
- ☐ Vimpat 150mg Tablets — Frequency* _____
- ☐ Vimpat 200mg Tablets — Frequency* _____
- ☐ Vimpat 10 mg/mL Oral Solution — Frequency* _____
- ☐ Keppra XR 500mg Tablets — Frequency** _____
- ☐ Keppra XR 750mg Tablets — Frequency** _____

*Vimpat Maximum Daily Dosage = 400mg **Keppra XR Maximum daily dosage = 3000mg

This section to be completed by the Attending Physician

Physician's First Name:

Physician's Last Name:

DEA #: State License #:

Expiration Date: / / Ph. # - -

Address:

City: State: Zip Code:

Diagnosis and/or Diagnostic Code(s): (Please select one.)

- ☐ **345.40** – Partial epilepsy with impairment of consciousness; without intractable epilepsy
- ☐ **345.50** – Partial epilepsy without impairment of consciousness; without intractable epilepsy
- ☐ **345.41** – Partial epilepsy with impairment of consciousness; with intractable epilepsy
- ☐ **345.51** – Partial epilepsy without impairment of consciousness; with intractable epilepsy

Please see attachment for FDA approved indications.

I hereby certify that the above named person is my patient and the medications received for the UCB Patient Assistance Program are only for the use of the patient named on this form. There will be no claim for reimbursement submitted concerning these medications to Medicare, Medicaid, or any third party, nor returned for credit. I understand UCB, Inc. has the right to revise, change, or terminate the UCB Patient Assistance Program at any time. I also certify that I am currently licensed with the appropriate state and federal authorities to prescribe and dispense a Schedule V Controlled Substance.

_____

PHYSICIAN SIGNATURE / PROFESSIONAL DESIGNATION

DATE: / /

Call 1-866-395-8366 if you have questions or need assistance.

Applications and prescriptions may be mailed or faxed to:

800-233-9141

Or

UCB Patient Assistance Program

PO Box 2198 Morrisville, PA 19067

UCB, Inc. reserves the right to change the provisions of this program at any time

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VIMPAT® (lacosamide) C

Patient Assistance Program

Patient (or Legal Guardian) Instructions

Form will be returned if information is incomplete. Incomplete forms will delay the application review process.

Gross Monthly Household Income: Please include your total GROSS MONTHLY HOUSEHOLD income. If that income comes from salary/wages/dividends, social security, social security supplemental income, disability, unemployment compensation, pension/annuity, alimony/child support, rental income or other (please specify), indicate the dollar amount. Attach most current W-2 forms or other proof of income. If there is NO household income, please submit a letter with the application.

Signature and Date: You, or your legal guardian, must sign and date the application attesting that the information provided is both complete and accurate.

All information contained in this application will only be used for the purpose of evaluating the patient's application for eligibility.

This section to be completed by Patient or Legal Guardian

Patient First Name:

Patient Last Name:

Address:

City: State: Zip Code:

Ph. #: - - Birth date: / /

Social Security #: - - Medicare ID #:

Alien Reg. #:

Gross Monthly Household Income of Applicant (Please attach most current documentation):

Salary/Wages/Dividends	$ .00	Pension/Annuity	$ .00
Social Security	$ .00	Alimony/Child Support	$ .00
Disability	$ .00	Other: _____	$ .00
Unemployed Compensation	$ .00	TOTAL/MONTH	$ .00

U.S. Resident ☐ Yes ☐ No

Sex: ☐ Male ☐ Female ☐ Unknown

Number of persons DEPENDENT upon primary income within family:

Are you currently enrolled in Medicare Part D? ☐ Yes ☐ No

Do you currently have prescription drug coverage other than Medicare Part D? ☐ Yes ☐ No

If enrolled in Medicare Part D, please provide a copy of the front and back of your Medicare Part D card.
Please indicate drug plan (PDP) name, address, & phone number.

I hereby certify that the above information is correct and complete. I authorize UCB, Inc. and its agents to review the medical and financial information provided. I also authorize UCB, Inc. to contact my prescribing physician, pharmacy or insurance company to discuss this application, and any information about me that may be related to this application. I understand that this product is being provided free of charge outside of Medicare, Medicaid, or any public or private third party. I certify that I will not submit any claims for reimbursement or credit for product received to Medicare, Medicaid, or any third party payer. I understand UCB, Inc. has the right to revise, change, or terminate the UCB Patient Assistance Program at any time.

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE: / /