

## UCB Patient Assistance Program

UCB is committed to assisting eligible patients who meet medical and financial criteria with access to the following UCB products.

CIMZIA<sup>®</sup> (certolizumab pegol)  
BRIVIACT<sup>®</sup> (brivaracetam) C-V  
VIMPAT<sup>®</sup> (lacosamide) C-V  
NEUPRO<sup>®</sup> (rotigotine transdermal system)  
KEPPRA<sup>®</sup> (levetiracetam)  
KEPPRA XR<sup>®</sup> (levetiracetam) extended release

## Eligibility

Financial assistance for UCB products may be available to patients with a valid prescription from a U.S. licensed health care practitioner. The program is not intended for clinics, hospitals and/or other institutions. The minimum eligibility requirements are as follows:

- Patient must reside in the United States, the District of Columbia, or Puerto Rico
- Patient must be uninsured or insured medically but with no prescription coverage
- Patients with certain Medicare Part D plans may be eligible and can apply to determine eligibility
- All applications must include a valid prescription from a U.S. licensed healthcare practitioner
- A patient's total household income cannot exceed 300% of the Federal Poverty Limit (FPL). Detailed information on the current Federal Poverty Limit can be found at the following web URL address: <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/>

All information provided in this application is subject to verification.

Patients may contact **UCBCares** with questions regarding the minimum qualifications.

If you believe you do not meet the minimum requirements listed above, please contact **UCBCares** by calling 844-599-CARE (2273) to determine whether other financial resources may be available to you.

## Application

If you believe you meet the minimum requirements for program eligibility, please complete sections 1 and 2 of this application, then have your physician complete section 3. If you believe you do not meet the minimum requirements listed above you may not qualify for the UCB Patient Assistance Program; however, you may contact **UCBCares** by calling 844-599-CARE (2273) to see if there are other financial resources available to you.

- Patient or patient representative completes Sections 1 and 2. Proof of income section **MUST** be completed and signed in order for application to be processed. Please note that proof of income, contained in section 2 titled "income information," **MUST** be completed and signed in order to process your application.
- Physician completes Section 3 and submits application along with a written prescription for the requested UCB product.



## SECTION 1 Patient Information

(to be completed by the patient or authorized patient representative)

Please print clearly. All fields required. Please note all requested information must be completed in order to avoid delay or possible denial of your application. For applicants requesting VIMPAT® C-V or BRIVIACT® C-V, please also include a valid, current driver's license number for the patient/authorized patient representative or an official government issued ID number.

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Does the patient currently reside in the U.S.?:  Yes or  No Sex:  Male or  Female

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ or if applicable Alien ID #: \_\_\_\_\_

If the applicant is requesting VIMPAT or BRIVIACT please provide a current, valid driver's license number for the patient/authorized patient representative or official government issued ID number.

\_\_\_\_\_ State: \_\_\_\_\_

Is this address your shipping address?:  Yes or  No If the answer is No provide shipping address below.

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have prescription drug coverage?:  Yes or  No or  NA

If you answered yes above, please answer the questions below. If not applicable please check NA:

Prescription Drug Plan (PDP) Name: (e.g., Humana, Blue Shield, United, Aetna, etc.)

\_\_\_\_\_

PDP Contact Number: \_\_\_\_\_

Do you have Medicare Part D?:  Yes or  No

Medicare ID #: \_\_\_\_\_

**ALTERNATE CONTACT:** By providing this information, you consent to UCB program administrators sharing or discussing your private health information with this person.

First and Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



## SECTION 2 Income Information

**Gross Monthly Household Income:** Please include your TOTAL GROSS MONTHLY HOUSEHOLD income. If that income comes from salary/wages/dividends, Social Security, supplemental income, disability, unemployment compensation, pension/annuity, alimony/child support, rental income or other (please specify), indicate the dollar amount. If there is NO household income, please submit a letter with this application (signed and dated by the patient or patient's authorized representative) to explain that the patient receives no income.

**Signature and Date:** You or your authorized patient representative must sign and date this application.

### List All Sources, Gross Monthly Amounts

Salary/Wages:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00	Social Security:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00
Child Support /Alimony:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00	Disability:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00
Retirement:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00	Social Security Pension/ Unemployment:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00
Work Comp:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00	<b>Total Gross Household Monthly Income:</b>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00

Number of persons DEPENDENT upon primary income within the family: \_\_\_\_\_

### Applicant Declarations

I certify and promise that: all information provided in this application is complete and accurate, including all copies of documents proving my income; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare Part D, if applicable); and I will contact the UCB Patient Assistance Program (Program) if any of my information about my income, financial status, prescription drug coverage, or insurance changes. If audited, I agree to provide the necessary documents to support the information on this application.

I understand that completing this application does not ensure that I will qualify for this Program and that the Program assistance will terminate if UCB or its agents become aware of any fraud or if the UCB medication being provided is no longer prescribed for me. I also understand that UCB reserves the right to modify the application form, modify or discontinue the Program, or terminate assistance at any time and without notice.

\_\_\_\_\_  
Patient's (or authorized patient representative) Signature:

\_\_\_\_\_  
Date:

### Authorization for Use and Disclosure of Protected Health Information

I understand that in order for the UCB Patient Assistance Program to provide me with assistance, it will need to obtain, review, use, and disclose my personal health information (PHI), including information relating to my medical condition and information on my application form. I agree to allow the Program to contact me via mail, telephone or email to carry out these services.

I authorize my physician(s), pharmacy, and my health plan(s) to share information about me or my medical condition, including my PHI, with the UCB Patient Assistance Program, UCB, and/or their agents, which may administer the Program. This information will be used and shared to determine whether I am eligible for insurance coverage or other reimbursement for the medication(s) for which I am applying, whether I am eligible for the Program, to administer the Program, and to assess the quality of Program services provided by UCB, its vendors and its contractors. I understand that once the Program receives my information, it may be re-disclosed and no longer protected by federal privacy regulations.

I understand that if I do not sign this authorization or if I cancel it, I cannot participate in the Program. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician, and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization.

I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

\_\_\_\_\_  
Patient's (or authorized patient representative) Signature:

\_\_\_\_\_  
Date:

### SECTION 3 Prescription Information (to be completed by prescribing physician)

Please include a complete prescription with this application.

Physician Full Name: \_\_\_\_\_

Office Contact Full Name: \_\_\_\_\_

DEA #: \_\_\_\_\_ State License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Fax: \_\_\_\_\_

Exp Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: \_\_\_\_\_

Address: (No P.O. Box) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Concomitant medication(s) patient is taking: \_\_\_\_\_

Drug Name and Dose Selection (please check appropriate box(es) below), and quantity will be determined by the prescription accompanying this request upon approval. Approvals will be valid for up to 12 months and may periodically require verification.


#### PLEASE INCLUDE A COMPLETE PRESCRIPTION WITH THIS APPLICATION.

CIMZIA®	VIMPAT® C-V Tablets and Oral Solution	BRIVIACT® C-V Tablets and Oral Solution	NEUPRO® Transdermal System	KEPPRA® and KEPPRA XR® Tablets
<input type="checkbox"/> CIMZIA 200mg/mL PFS	<input type="checkbox"/> VIMPAT 50mg	<input type="checkbox"/> BRIVIACT 10mg	<input type="checkbox"/> NEUPRO 1mg/24hr	<input type="checkbox"/> KEPPRA 250mg
<input type="checkbox"/> CIMZIA 200mg Lyo 2 Vials + 2 Vials WFI	<input type="checkbox"/> VIMPAT 100mg	<input type="checkbox"/> BRIVIACT 25mg	<input type="checkbox"/> NEUPRO 2mg/24hr	<input type="checkbox"/> KEPPRA 500mg
	<input type="checkbox"/> VIMPAT 150mg	<input type="checkbox"/> BRIVIACT 50mg	<input type="checkbox"/> NEUPRO 3mg/24hr	<input type="checkbox"/> KEPPRA 750mg
	<input type="checkbox"/> VIMPAT 200mg	<input type="checkbox"/> BRIVIACT 75mg	<input type="checkbox"/> NEUPRO 4mg/24hr	<input type="checkbox"/> KEPPRA 1000mg
	<input type="checkbox"/> VIMPAT 10mg/mL	<input type="checkbox"/> BRIVIACT 100mg	<input type="checkbox"/> NEUPRO 6mg/24hr	<input type="checkbox"/> KEPPRA 100mg/mL
		<input type="checkbox"/> BRIVIACT 10mg/mL	<input type="checkbox"/> NEUPRO 8mg/24hr	<input type="checkbox"/> KEPPRA XR 500mg
				<input type="checkbox"/> KEPPRA XR 750mg


I certify the information submitted on this application is true and that the prescription drug(s) received as a result of this application will be used to treat ONLY the patient identified above. I will not charge for or sell the prescription drug(s). I further certify that the use of the prescription drug(s) identified above is medically necessary and I will supervise the patient's treatment accordingly.

Physician's Signature: \_\_\_\_\_


Date: \_\_\_\_\_




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