UCB Patient Assistance Program

The UCB Patient Assistance Program currently supports the following products.

CIMZIA® (certolizumab pegol)
BRIVIACT® (brivaracetam) CV
VIMPAT® (lacosamide) CV
NEUPRO® (rotigotine transdermal system)

Eligibility

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 drug coverage
- Insured patients who cannot afford their medication will be considered only after exhausting all other coverage options
- Cimzia patients with government insurance, such as Medicare and TRICARE are not eligible for the patient assistance program
- All applications must include a valid prescription from a U.S. licensed healthcare practitioner
- Prescriptions for Briviact CV and Vimpat CV must be signed by an MD or DO in compliance with Texas Pharmacy Regulations, where the PAP pharmacy is located
- 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.

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
- 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® CV or BRIVIACT® CV, 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: ____________________

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

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 #: ___________________________________________

Patient Preferred Language: ________________________________________________________________________________________

If requesting VIMPAT or BRIVIACT please provide the following information found on a current official government ID

ID Type_____________________________________________ ID#____________________________________State:_________________

Do you have prescription drug coverage?: ☐ Yes  or  ☐ No  or  ☐ Unknown

If you answered yes above, please answer the questions below.

Insurance Plan Name: (e.g., Humana, Blue Shield, United, Aetna, etc.)

_________________________________________________________________________________________________________________

Insurance Plan ID Number: _______________________________________________________________________________________________________

Insurance Plan 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. Please list no more than two (2) persons authorized to discuss your private health information with UCB program administrators. This may include health care professionals or medical office staff.

First and Last Name: ______________________________________________________________________________________________________

Relationship: ________________________________________________________________ Phone: ____________________________________________________

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.

All reported income is subject to verification by consumer credit agencies. Where income verification is not possible, patients will be required to provide proof of income.

List All Sources, Gross Monthly Amounts

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary/Wages</td>
<td>$------.00</td>
</tr>
<tr>
<td>Child Support/Alimony</td>
<td>$------.00</td>
</tr>
<tr>
<td>Retirement</td>
<td>$------.00</td>
</tr>
<tr>
<td>Work Comp</td>
<td>$------.00</td>
</tr>
<tr>
<td>Social Security</td>
<td>$------.00</td>
</tr>
<tr>
<td>Disability</td>
<td>$------.00</td>
</tr>
<tr>
<td>Social Security Pension/Unemployment</td>
<td>$------.00</td>
</tr>
<tr>
<td>Total Gross Household Monthly Income</td>
<td>$------.00</td>
</tr>
</tbody>
</table>

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 information regarding my income; I am authorized to sign this application; 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. Should an investigative consumer report be utilized, you will have the right to request a complete and accurate disclosure of the nature and scope of the investigation requested and a written summary of your rights under the Fair Credit Reporting Act. 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  Prescriber Information  (to be completed by prescribing physician)

A valid prescription must be provided by your healthcare professional

Physician Full Name: ____________________________________________________________

Office Contact Full Name: ______________________________________________________

Address: (No P.O. Box) _________________________________________________________

City: ___________________________ State: ___________________________ Zip: __________

Phone: ________________________ Fax: _________________________________

DEA #: _________________________ NPI #: _________________________________

State License #: ___________________________ Exp Date: __________ - __________ - __________

Patient First and Last Name: ________________________________________________

Known Allergies: ____________________________________________________________

Concomitant medication(s) patient is taking:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Please check the appropriate box(es) below for drug name and dose selection. Medication quantity will be determined by the accompanying prescription, upon approval. Approvals may be valid for up to 24 months and may periodically require verification.

PLEASE INCLUDE A COMPLETE PRESCRIPTION WITH THIS APPLICATION.

Prescriptions for Briviact CV and Vimpat CV require MD or DO signature in compliance with Texas Pharmacy Regulations.

<table>
<thead>
<tr>
<th>CIMZIA®</th>
<th>VIMPAT® CV Tablets and Oral Solution</th>
<th>BRIVIACT® CV Tablets and Oral Solution</th>
<th>NEUPRO® Transdermal System</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ CIMZIA Starter Kit</td>
<td>□ VIMPAT 50mg</td>
<td>□ BRIVIACT 10mg</td>
<td>□ NEUPRO 1mg/24hr</td>
</tr>
<tr>
<td>6-200mg/mL PFS</td>
<td>□ VIMPAT 100mg</td>
<td>□ BRIVIACT 25mg</td>
<td>□ NEUPRO 2mg/24hr</td>
</tr>
<tr>
<td>□ CIMZIA</td>
<td>□ VIMPAT 150mg</td>
<td>□ BRIVIACT 50mg</td>
<td>□ NEUPRO 3mg/24hr</td>
</tr>
<tr>
<td>2-200mg/mL PFS</td>
<td>□ VIMPAT 200mg</td>
<td>□ BRIVIACT 75mg</td>
<td>□ NEUPRO 4mg/24hr</td>
</tr>
<tr>
<td>□ CIMZIA LYO</td>
<td>□ VIMPAT 10mg/mL</td>
<td>□ BRIVIACT 100mg</td>
<td>□ NEUPRO 6mg/24h</td>
</tr>
<tr>
<td>2-200mg/mL Vials +2 Vials SWI</td>
<td>□ BRIVIACT 10mg/mL</td>
<td>□ BRIVIACT 10mg/mL</td>
<td>□ NEUPRO 8mg/24h</td>
</tr>
</tbody>
</table>

UCB, Inc.
UCB Patient Assistance Program
1330 Enclave Parkway
Suite 125
Houston, TX 77077

Fax #: (855) 880-5262
Phone #: (877) 785-8906
Email: ucb-pap@cardinalhealth.com

© 2019, UCB, Inc. All Rights Reserved. All trademarks belong to the UCB Group of Companies.
VIMPAT® is a registered trademark under license from Harris FRC Corporation. USP-MP.0216-0003(1)