OTSUKA PATIENT ASSISTANCE FOUNDATION, INC.
PO Box 501878, San Diego, CA 92150-1878
PHONE: 1-855-727-6274 **FAX**: 1-844-727-6274
HOURS: Monday-Friday 8am-8pm ET

Otsuka
OTSUKA PATIENT ASSISTANCE
FOUNDATION

SAMSCA®(tolvaptan) RE-INITIATION OF THERAPY

Today's Date: (mm/dd/yyyy): _______________

I, ____, attest the patient, ____,

date of birth, _______________, re-initiated therapy in the hospital for SAMSCA® (tolvaptan) tablets. The patient was accepted into the Otsuka Patient Assistance Foundation Inc. (OPAF) within the last 12 months and would like to re-apply for assistance.

PRESCRIBER INFORMATION:

Prescriber Name: ________________________________ State License #: ____________________

Tax ID #: ____________________ NPI#: ____________________ DEA#: ____________________

Direct Contact's Name: ____

Site Name: ____

Address: ____________________ City: ____________________ State: ________ ZIP: ____________

Contact Direct Phone: ____________________ Ext: __________ Contact Fax: ____________________

Contact Email: ____

PATIENT INFORMATION:

First Name: ____________________ Last Name: ____________________ MI: _____

DOB (mm/dd/yyyy): ____________________

Patient Address: ____________________ City: ____________________ State: _______ ZIP: ____________

Patient Cell Number: ____________________ Patient Email: ____________________

PRESCRIPTION INFORMATION:

ICD-10 Code: ____________________ Medication: ____________________

Diagnosis: ____

Dose of SAMSCA: (Check one) ☐ 30mg ☐ 15mg (Check one) ☐ QD ☐ BID

Quantity: ________(SAMSCA is indicated for no more than 30 Days Supply)

Date of Hospital Admission (mm/dd/yyyy): _______________ Date of Hospital discharge or expected discharge (mm/dd/yyyy): _______________

Dosage while in Hospital: (Check one) ☐ 30mg ☐ 15mg Dosing frequency: _______

Number of SAMSCA tablets dispensed at hospital discharge: _______

I appoint the Otsuka Patient Assistance Foundation, Inc. (hereafter, referred to as OPAF) to convey this prescription to the dispensing pharmacy. I certify that therapy with the above-mentioned product is medically necessary for this patient and I have reviewed the current Prescribing Information for the prescribed product. I attest that I am not on the HHS/OIG List of Excluded Individuals and Entities and that I am presently authorized under state law to prescribe this medication. I authorize and appoint OPAF to convey on my behalf any prescription information delivered to the dispensing pharmacy. For the purposes of transmitting this prescription, I authorize OPAF and its affiliates as my agent for these limited purposes to forward this prescription electronically, or via fax, or via mail to the dispensing pharmacy. I certify that any medication received will be used only for the patient named on this application and will not be offered for sale, trade, or barter. I acknowledge that OPAF is a free goods, non-profit program that assists patients that have been approved for assistance by meeting specific criteria. I acknowledge, that at any time, I can change or withdraw this prescription on the patient's behalf due to the medical needs of the patient by calling 1-855-727-6274 or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation Inc., PO Box 501878, San Diego, CA 92150-1878. I understand that OPAF may revise, change, or terminate programs at any time.

Dispense as written ☐

Prescriber's Name: ____

Sign Here ____ Date: ____________________

Samsca®
(tolvaptan)

Please see FULL PRESCRIBING INFORMATION including **BOXED WARNING** and MEDICATION GUIDE for SAMSCA®(tolvaptan) tablets at www.samsca.com .

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