

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

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): \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Patient Cell Number: \_\_\_\_\_ Patient Email: \_\_\_\_\_

### PRESCRIPTION INFORMATION:

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 administered during hospital stay: \_\_\_\_\_

Number of SAMSCA tablets dispensed at hospital discharge: \_\_\_\_\_

I appoint the Otsuka Patient Assistance Foundation (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 4530, Chesterfield, MO 63006. I understand that OPAF may revise, change, or terminate programs at any time.

Dispense as written

Prescriber's Name: \_\_\_\_\_



\_\_\_\_\_

Date: (mm/dd/yyyy) \_\_\_\_\_

**Samsca**  
(tolvaptan)

Please see [FULL PRESCRIBING INFORMATION](#) including BOXED WARNING and [MEDICATION GUIDE](#) for

SAMSCA® (tolvaptan) tablets at [www.samsca.com](http://www.samsca.com).