Intra-Cellular Therapies
Patient Assistance Program
Application & Prescription

CAPLYTA™ (lumateperone) capsules

Description of Service and Instructions

PATIENT ASSISTANCE PROGRAM (PAP)

At Intra-Cellular Therapies, Inc., we understand that some patients may have financial situations that make it difficult to pay for their prescriptions. The Intra-Cellular Therapies Patient Assistance Program is available to eligible patients who have been prescribed CAPLYTA™ (lumateperone) capsules and do not have health insurance. All applications are reviewed on a case-by-case basis in accordance with program criteria.

To be eligible, patient must be:

- ❑ **Diagnosed with schizophrenia and at least 18 years of age**
- ❑ **Without prescription insurance coverage, including Medicare and Medicaid**
- ❑ **A citizen or permanent resident of the United States, excluding Puerto Rico**
- ❑ **Within 300% of the federal poverty level**

Instructions

Patient Confidentiality:

Patient confidentiality is of the utmost importance to us. All patient information will remain strictly confidential.

Important Reminder:

Please be certain that all applicable pages of the Patient Enrollment and Prescription are fully completed and include all appropriate documentation when submitting this form. Incomplete forms slow the review.

1

Patient Attestation of No Insurance Coverage *(to be completed by patient or authorized representative)*

By Checking this box, I attest and certify that I have no health insurance coverage. ☐

The Intra-Cellular Therapies Patient Assistance Program is only available to uninsured patients. If you have health insurance, ask your doctor to submit your CAPLYTA prescription to your insurance provider.

2

Financial Information *(to be completed by patient or authorized representative)*

Current Annual Household Income: $_____ Number of People in Household_____

If there is no household income, indicate how the patient/household is being supported:

_____

3

3a. Patient Consent *(for the use and disclosure of your protected health information for treatment and healthcare operations)*

To operate the **Intra-Cellular Therapies Patient Assistance Program (PAP)** for CAPLYTA (lumateperone), the PAP needs some information about you. When you sign below, you are authorizing any pharmacy, healthcare provider, and/or others who are in possession of your personal information, including health information, to share information about you with the PAP, RxCrossroads by McKesson and their affiliates, employees, agents, vendors, and business partners who may be assisting with the administration of the PAP ("Agents"), and you are authorizing the Agents to share, use, and disclose your information for the purposes of operating the program.

The Agents may receive, share, and use the following information:

- Information in this application
- Information about your medical conditions, treatment, current and future medications
- Other information the Agents may obtain to operate the PAP
- The Agents may share your information with your healthcare providers and pharmacists
- Your healthcare providers and pharmacists may share your information with the Agents

The Agents may share your information for the following purposes:

- To review your application and to contact you or your healthcare provider, if necessary
- To contact your pharmacies and healthcare providers relating to your participation in the PAP, including personal information and information about your prescription medications

X_____/ _____/_____

Patient/Legal Guardian/Caregiver Printed Name / Signature / Date

Relationship to Patient ☐ **Self** ☐ **Authorized Representative** ☐ **Caregiver**

3b. Patient Authorization *(for uses and disclosures of patient's protected health information not allowed within the privacy laws)*

By my signature below, I also agree to the following:

- I understand that if my information is shared in the manner stated above, federal and state privacy laws may no longer protect my PHI and may not prohibit its further disclosure; however, the Agents have committed to use and disclose my PHI only as stated in this form
- I authorize Intra-Cellular Therapies, Inc., (ITCI) and companies working with ITCI to provide me with support services related to ITCI products (collectively called "Support Services")
- I understand, agree and authorize that any individual providing Support Services is not employed by my healthcare provider. I authorize ITCI and companies working with ITCI to contact me to provide Support Services and information by mail, telephone call, and other means. If I provided my cell phone number on this form, I agree to receive calls at that number, from or on behalf of ITCI
- I understand and agree that these calls may be deemed telemarketing under applicable law
- I understand if I do not sign or refuse to sign this form, I will not be eligible for the PAP
- I understand that I can cancel my consent at any time by sending a written notice to the PAP at the address on this application. If I cancel my consent, I will no longer qualify for the PAP. My healthcare providers will no longer share my PHI with the Agents after the date that the Agents receive and process my cancellation letter, but this will not affect information or disclosures shared before that time. Additionally, once my cancellation is received and processed by the Receiving Entities, my participation in the PAP will be terminated, and after my participation is terminated, the Receiving Entities will only maintain and use my information for legal and regulatory purposes
- I agree to follow the rules and conditions of the PAP
- I have been provided a copy of this authorization
- I understand that the PAP will decide if I qualify for this program. I understand that my application might not be approved
- I will not submit any claim for reimbursement to any third-party insurer for any product provided to me under the PAP
- I agree to notify the PAP of changes to my income or insurance status that may impact my eligibility for the PAP
- I understand the PAP may change or end at any time without advance notice
- I authorize the PAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf
- I understand and agree that if the Agent asks, I will provide documentation that proves the information I have certified in this application is true, correct, and complete

X_____/_____/_____

Patient/Legal Guardian/Caregiver Printed Name / Signature / Date

Relationship to Patient ☐ **Self** ☐ **Authorized Representative** ☐ **Caregiver**

3c. Patient Authorization *(to pull soft credit report for purpose of verifying financial information, under the Fair Credit Reporting Act)*

I understand that I am providing 'written instructions' to the PAP Agents under the Fair Credit Reporting Act to obtain information from my credit profile or other information from Experian Health in conjunction with my application. The PAP may use my name, date of birth, address, and social security number to obtain my consumer report including, but not limited to, information regarding my household size and income. My consumer report will be used to estimate my household income as part of the process to decide if I am eligible to receive free medication from the PAP. This soft credit inquiry will not impact my credit score.

X_____/_____/_____

Patient/Legal Guardian/Caregiver Printed Name / Signature / Date

Relationship to Patient ☐ **Self** ☐ **Authorized Representative** ☐ **Caregiver**

4

4a. Patient Information (Use "N/A" if not applicable) *(to be completed by patient or authorized representative)*

Name (First, Last, Suffix) _____

Date of Birth (MM/DD/YYYY) _____ **Gender** ☐ **Male** ☐ **Female**

Home Address _____

City _____ **State** _____ **Zip Code** _____

Authorized Representative _____ **Relationship to Patient** _____

Home Phone _____ **Cell Phone** _____

4b. Patient Clinical Information (Use "N/A" if not applicable) *(to be completed by prescriber)*

Qualifying Diagnosis *(ICD 10 Code)*

×	Source	Dx Code	Dx Description
☐	ICD-10	F20.9	SCHIZOPHRENIA, UNSPECIFIED
☐	ICD-10	F20.0	PARANOID SCHIZOPHRENIA
☐	ICD-10	F20.3	UNDIFFERENTIATED SCHIZOPHRENIA
☐	ICD-10	F20.89	OTHER SCHIZOPHRENIA
☐	ICD-10	F20.1	DISORGANIZED SCHIZOPHRENIA
☐	ICD-10	F20.5	RESIDUAL SCHIZOPHRENIA
☐	ICD-10	F20.2	CATATONIC SCHIZOPHRENIA

List Allergies	List Other Medications

4c. PRESCRIPTION *(to be completed by prescriber)*

Prescription: CAPLYTA (lumateperone) 42 mg capsules ☐ **#90**

Directions: _____

Refills: # of authorized refills: _____ **OR** ☐ **Authorize refills for 1-year enrollment period**

***Note 1**: If prescribing other than #90, prescriber must call Program Pharmacy at 1-888-481-4824 to authorize override*

***Note 2**: Authorized refills must be ordered by patient or prescriber by calling 1-888-481-4824*

Prescriber Signature X_____ **Date**_____

5

5a. Prescriber Information *(to be completed by prescriber)*

Prescriber Name _____ **NPI Number** _____
Office Address _____
City _____ **State** _____ **Zip Code** _____
Primary Phone _____ **Secondary Phone** _____ **Fax** _____

Patient's CAPLYTA (lumateperone) will be shipped to prescriber's office address unless otherwise instructed by presciber by calling PAP at 1-888-481-4824

5b. Prescriber Attestation *- signature required (to be completed by prescriber)*

I attest that the patient and healthcare prescriber information contained in this Patient Enrollment Form & Prescription is complete and accurate to the best of my knowledge. I have prescribed CAPLYTA (lumateperone) 42 mg capsules and attest that this prescription medication is medically necessary for the patient and that I have instructed the patient that it is to be used as only I have directed. I further attest that I will be supervising the patient's treatments, and that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to the Intra-Cellular Therapies Patient Assistance Program for the purposes of verifying the patient has no insurance to cover the cost of CAPLYTA. My team has exercised due diligence in verifying that this patient has no health insurance coverage.
I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free medicine received under the Patient Assistance Program and my team has informed the patient of this requirement.
My signature below (required), verifies that I have read and agree to this Section 5, Prescriber Attestation.

Prescriber Signature X _____ **Date** _____

(NOTE: Patient Application & Prescription requests cannot be processed without signed Prescription and Prescriber Attestation. Actual signature is required, no signature stamp.)

Please fax the entire Enrollment Form to the
Intra-Cellular Therapies Patient Assistance Program
1-888-481-4838
or mail form to
Intra-Cellular Therapies Patient Assistance Program
P.O. Box 5554 Louisville, KY 40255

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