



Patient Assistance Program

Patient (or Legal Guardian) Instructions

Form will be returned if information is incomplete. Incomplete forms will delay the application review process.

Gross Monthly Household Income: Please include your total GROSS MONTHLY HOUSEHOLD income. If that income comes from salary/wages/dividends, social security, social security supplemental income, disability, unemployment compensation, pension/annuity, alimony/child support, rental income or other (please specify), indicate the dollar amount. Attach most current W-2 forms or other proof of income. If there is NO household income, please submit a letter with the application.

Signature and Date: You, or your legal guardian, must sign and date the application attesting that the information provided is both complete and accurate.

All information contained in this application will only be used for the purpose of evaluating the patient's application for eligibility.

This section to be completed by Patient or Legal Guardian

Patient First Name:

Patient Last Name:

Address:

City: State: Zip Code:

Ph. #: - - Birth date: / /

Social Security #: - - Medicare ID #:

Gross Monthly Household Income of Applicant (Please attach most current documentation):

Salary/Wages/Dividends	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00	Pension/Annuity	\$ <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"/> .00	Alimony/Child Support	\$ <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"/> .00	Other:	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00
Unemployed Compensation	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00	TOTAL/MONTH	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> .00

U.S. Citizen Yes No Sex: Male Female Unknown

Number of persons DEPENDENT upon primary income within family:

Are you currently enrolled in Medicare Part D? Yes No

Do you currently have prescription drug coverage other than Medicare Part D? Yes No

If enrolled in Medicare Part D, please provide a copy of the front and back of your Medicare Part D card. Please indicate drug plan (PDP) name, address, & phone number.

I hereby certify that the above information is correct and complete. I authorize UCB, Inc. and its agents to review the medical and financial information provided. I also authorize UCB, Inc. to contact my prescribing physician, pharmacy or insurance company to discuss this application, and any information about me that may be related to this application. I understand that this product is being provided free of charge outside of Medicare, Medicaid, or any public or private third party. I certify that I will not submit any claims for reimbursement or credit for product received to Medicare, Medicaid, or any third party payer. I understand UCB, Inc. has the right to revise, change, or terminate the UCB Patient Assistance Program at any time.

DATE: / /

PATIENT OR LEGAL GUARDIAN SIGNATURE



Patient Assistance Program

Attending Physician Instructions

Please complete all the required information below. In the space provided, indicate the patient's diagnosis and/or diagnostic code(s). Gather all information (including prescription and most current proof of income) **and please ensure that all documents are signed and dated.** Mail the completed application to the UCB Patient Assistance Program at the address below.

se select one of the following drug strengths and p de frequency. Attach your prescription to this form.

CHECK ONE STRENGTH ONLY

Vimpat 50mg Tablets	Frequency _____	Keppra XR 500mg Tablets	Frequency _____
Vimpat 100mg Tablets	Frequency _____	Keppra XR 750mg Tablets	Frequency _____
Vimpat 150mg Tablets	Frequency _____		
Vimpat 200mg Tablets	Frequency _____		

This section to be completed by the Attending Physician

Physician's First Name:

Physician's Last Name:

DEA #: State License #:

Expiration Date: / / Ph. #: - -

Address:

City: State: Zip Code:

Diagnosis and/or Diagnostic Code(s): (Please specify seizure type)

I hereby certify that the above named person is my patient and the medications received for the UCB Patient Assistance Program are only for the use of the patient named on this form. There will be no claim for reimbursement submitted concerning these medications to Medicare, Medicaid, or any third party, nor returned for credit. I understand UCB, Inc. has the right to revise, change, or terminate the UCB Patient Assistance Program at any time. I also certify that I am currently licensed with the appropriate state and federal authorities to prescribe and dispense a Schedule V Controlled Substance.

DATE: / /

PHYSICIAN SIGNATURE / PROFESSIONAL DESIGNATION

Call 1-866-395-8366 if you have questions or need assistance.

UCB, Inc. reserves the right to change the provisions of this program at any time.

UCB Patient Assistance Program
PO Box 2198 • Morrisville, PA 19067-0698

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