Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Reset Form

Patient Assistance Program

ARISTADA® CARE SUPPORT

ARISTADA INITIO® aripiprazole lauroxil extended-release injectable suspension 675 mg

ARISTADA® aripiprazole lauroxil extended-release injectable suspension 441 mg 662 mg 882 mg 1064 mg

COMPLETE ALL FIELDS TO AVOID PROCESSING DELAYS. PRESCRIPTION ONLY VALID IF FAXED. FAX COMPLETED FORM TO: 1-844-464-7171
QUESTIONS? CALL 1-866-ARISTADA (1-866-274-7823), 9 AM-8 PM (ET)

Prescriber Signatures (page 1) and Patient Signatures (pages 1 and 2) required.

1. PRESCRIBER OR FACILITY INFORMATION

Prescriber Name
(First) (Last)
Tax ID # State License #
NPI # PTAN #
Facility Name
Facility Phone # Fax #
Address
City State Zip Code
Staff Name Staff Phone #
Staff Email Address
Additional Information

2. PATIENT INFORMATION

Name
(First) (Middle Initial) (Last)
Date of Birth Last 4 digits of SSN
Gender ❑ Male ❑ Female ❑ _____
Address
City State Zip Code
Mobile Phone # Home Phone #
Phone Instructions (Best Number)
Email Address

→ *INSTRUCT PATIENT TO LIST ALTERNATE CONTACTS ON PAGE 2.*

3. PATIENT DIAGNOSIS

Primary Diagnosis Code:

- ❑ F20.0 Paranoid schizophrenia
- ❑ F20.1 Disorganized schizophrenia
- ❑ F20.2 Catatonic schizophrenia
- ❑ F20.3 Undifferentiated schizophrenia
- ❑ F20.5 Residual schizophrenia
- ❑ F20.89 Other schizophrenia
- ❑ F20.9 Schizophrenia, unspecified

Patient has tried and failed the following medications

Any known allergies?

List concurrent medications

4. PATIENT ASSISTANCE PROGRAM (PAP)

❑ Check here if you would like to be assessed for the PAP.
I am a US Resident. ❑ Yes ❑ No

FINANCIAL INFORMATION
(ALL VALUES SHOULD REFLECT YEARLY AMOUNTS FOR ENTIRE HOUSEHOLD)

Total Gross Yearly Income: _____

Household Size: _____
(Number of people who contribute to or are dependent on your household income.)

❑ Attached is a copy of my most recent federal tax return

❑ I do not file federal taxes
(Additional follow up or documentation may be required for patients who do not file taxes.)

❑ I understand that to qualify for the PAP, my household income and household size must meet program requirements. I certify that my household size and household income, provided above, are accurate, as is my income documentation. I understand that my eligibility will be based on additional program requirements and, if approved, I must continue to meet eligibility requirements on an ongoing basis as defined by the program in order to receive benefits. Subject to continuing eligibility, patients will be approved for 6 months. Patients requiring assistance beyond 6 months will be required to reapply for continued program eligibility. I certify that I will notify the PAP at 1-866-274-7823 if my income or health insurance status changes in order to reassess my eligibility. I understand that if I am no longer eligible I will be removed from the program.

❑ I am not enrolled in, or covered by, any local, state, federal or other government program that pays for any portion of medication costs (including but not limited to Medicare or Medicaid, Medigap, VA, DOD, TRICARE or a residential correctional program).

❑ I understand that Alkermes, Inc. and the vendors associated with the PAP may obtain information about my credit profile from credit reporting agencies or other sources. I authorize this credit report to determine my PAP eligibility, and I acknowledge that this authorization extends to consumer reporting agencies and to subsequent reports in connection with PAP.

Your application may be subject to audit or request for additional documentation.

Patient's Signature X _____
Date of Signature _____ Phone # _____
OR Guardian/Legal Representative Signature‡ X _____
Authority/Relationship to Patient _____

‡If patient does not have capacity to act alone under state law, signature of guardian or authorized legal representative is required.

5. PRESCRIPTION INFORMATION

Patient Name _____
(Required – Please print full name)
Provider State License # Refills

- ❑ Inject ARISTADA 441mg monthly
- ❑ Inject ARISTADA 662mg monthly
- ❑ Inject ARISTADA 882mg monthly
- ❑ Inject ARISTADA 882mg every 6 weeks
- ❑ Inject ARISTADA 1064mg every 2 months
- ❑ Inject ARISTADA INITIO 675mg once as directed Qty: 1 Refills: 0

(Complete refills to minimize interruption in ARISTADA therapy)

By signing below, I certify that the therapy above is medically necessary. I authorize Alkermes, its affiliates, representatives and agents as my designated agents to forward the prescription, by fax or other mode of delivery, to a pharmacy for fulfillment.

Dispense as Written _____ Date _____
Prescriber Signature†
OR
Substitution Permitted _____ Date _____
Prescriber Signature†

†Prescriber Signature must be the same as the Prescriber Name. No stamps allowed.

6. PRESCRIBER ATTESTATION

By signing below, I verify that the information provided in this ARISTADA Care Support enrollment form is complete and accurate to the best of my knowledge. I understand that Alkermes, Inc., reserves the right at any time and for any reason, without notice, to modify this ARISTADA Care Support enrollment form or to modify or discontinue any services or assistance provided through ARISTADA Care Support. Finally, I authorize Alkermes, its affiliates, representatives and agents as my designated agents to use and disclose my patient's health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through ARISTADA Care Support, to forward the above prescription, by fax or other mode of delivery, to a pharmacy for fulfillment.

I authorize UBC to use the Surescripts network on my behalf to verify patient's health insurance information for participation in this program. Alkermes will notify me if the information provided by Surescripts to UBC on behalf of me renders the patient ineligible for this program. I agree to comply with all Surescripts' terms and conditions including confidentiality, privacy and security, applicable laws, and use of data with respect to any information provided to me that was obtained by UBC from Surescripts, on behalf of me. All Surescripts disclaimers apply. A full list of terms and conditions is available at https://ubc.com/surescriptsterms/.

Prescriber Signature X _____ Date _____

PLEASE SEE IMPORTANT SAFETY INFORMATION INCLUDING BOXED WARNING ON PAGE 3. PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE FOR ARISTADA INITIO, PRESCRIBING INFORMATION AND MEDICATION GUIDE FOR ARISTADA, OR VISIT ARISTADA.COM. PLEASE REVIEW MEDICATION GUIDE WITH PATIENTS.

Patient Assistance Program

PATIENTS SHOULD COMPLETE ALL FIELDS ON THIS PAGE.

QUESTIONS? CALL 1-866-ARISTADA (1-866-274-7823), 9 AM–8 PM (ET)

7. ALTERNATE PATIENT CONTACT(S)

By signing below, I authorize my Contact(s), listed below, to receive logistical and administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding delivery of ARISTADA INITIO® and/or ARISTADA®. Alkermes is not liable for any decision(s) made by the Contact(s) or actions taken in reliance on such Contact(s) decisions. Please list any Contacts authorized as set forth above:

Designee Name (1)	Relationship	Phone #	Email
Designee Name (2)	Relationship	Phone #	Email

Patient's Signature X	Print Name	Date
OR Guardian/Legal Representative Signature‡ X	Authority/Relationship to Patient	

‡If patient does not have capacity to act alone under state law, signature of guardian or authorized legal representative is required.

8. PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing and printing my name below, I authorize: 1. my prescribing healthcare provider, **2.** the healthcare provider who will administer ARISTADA INITIO® and/or ARISTADA® to me, **3.** the pharmacy(ies) to which my ARISTADA INITIO® and/or ARISTADA® prescription is sent for fulfillment (the "Pharmacy"), and **4.** my health plans and insurers (collectively, my "Healthcare Entities") to use and disclose to: **1.** Alkermes, Inc. and the companies working with Alkermes, Inc. to provide the ARISTADA INITIO® and/or ARISTADA® patient support services I request, which are United BioSource Corporation, AllCare Plus Pharmacy, Inc. (collectively, "Alkermes") and **2.** my Contact(s) listed above (together with Alkermes, the "Recipients") health information related to my medical condition, including information, my insurance coverage, as well as the information requested in this form (taken together, "Information") **for the specific purposes** of allowing Alkermes to facilitate: **1.** ordering, delivering and administering ARISTADA INITIO® and/or ARISTADA®, **2.** conducting reimbursement verification and obtaining payment from my health plan(s) and insurer(s), **3.** providing me with educational and therapy support services by mail, text-messaging, e-mail, and/or telephone, which may include sending me product information materials and treatment reminders, and motivational messages, **4.** referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the costs of ARISTADA INITIO® and/or ARISTADA®. **Information May Be Further Disclosed:** I understand that Information disclosed pursuant to this authorization could be re-disclosed by a Recipient and may no longer be protected by federal privacy law (HIPAA).

I understand that signing this authorization is voluntary and if I do not sign this authorization it will not affect my ability to obtain treatment, insurance or insurance benefits from my Healthcare Entities. I understand, however, that if I do not sign this authorization, I will not be eligible to receive the educational, patient support or other services described above, which are being provided by, or on behalf of, Alkermes. I will consult with my healthcare provider before making any treatment decisions. I understand I have the right to receive a copy of this authorization after I sign. I understand that the Pharmacy may receive payment from Alkermes, Inc. in exchange for Information.

I may withdraw this authorization at any time by mailing or faxing a written request to ARISTADA Care Support, 852 Winter Street, Waltham, MA 02451, 1-844-464-7171. Withdrawal of this authorization will end my consent to further disclosures of Information authorized herein by my Healthcare Entities when they receive notice of my withdrawal, but will not affect previous disclosures and uses pursuant to this authorization or as permitted by applicable law. This authorization expires on the earlier of **(1)** five years from the date of signature below or **(2)** the maximum period permitted by applicable state law, unless I withdraw it earlier as set forth above.

For additional information about our privacy practices, please visit https://www.Alkermes.com/privacy-policy. You can request a copy of our privacy policy by emailing dataprotection@Alkermes.com.

Patient's Signature X	Print Name	Date
OR Guardian/Legal Representative Signature‡ X	Authority/Relationship to Patient	

‡If patient does not have capacity to act alone under state law, signature of guardian or authorized legal representative is required.

INDICATION and IMPORTANT SAFETY INFORMATION for ARISTADA INITIO® (aripiprazole lauroxil) and ARISTADA® (aripiprazole lauroxil) extended-release injectable suspension, for intramuscular use

INDICATION

ARISTADA INITIO, in combination with oral aripiprazole, is indicated for the initiation of ARISTADA when used for the treatment of schizophrenia in adults.

ARISTADA is indicated for the treatment of schizophrenia in adults.

IMPORTANT SAFETY INFORMATION

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. ARISTADA INITIO and ARISTADA are not approved for the treatment of patients with dementia-related psychosis.

Contraindication: Known hypersensitivity reaction to aripiprazole. Reactions have ranged from pruritus/urticaria to anaphylaxis.

Cerebrovascular Adverse Reactions, Including Stroke: Increased incidence of cerebrovascular adverse reactions (e.g., stroke, transient ischemic attack), including fatalities, have been reported in placebo-controlled trials of elderly patients with dementia-related psychosis treated with risperidone, aripiprazole, and olanzapine. ARISTADA INITIO and ARISTADA are not approved for the treatment of patients with dementia-related psychosis.

Potential for Dosing and Medication Errors: Medication errors, including substitution and dispensing errors, between ARISTADA INITIO and ARISTADA could occur. ARISTADA INITIO is intended for single administration in contrast to ARISTADA which is administered monthly, every 6 weeks, or every 8 weeks. Do not substitute ARISTADA INITIO for ARISTADA because of differing pharmacokinetic profiles.

Neuroleptic Malignant Syndrome (NMS): A potentially fatal symptom complex may occur with administration of antipsychotic drugs, including ARISTADA INITIO and ARISTADA. Clinical manifestations of NMS include hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy; 2) intensive symptomatic treatment and medical monitoring; and 3) treatment of any concomitant serious medical problems for which specific treatments are available.

Tardive Dyskinesia (TD): The risk of developing TD (a syndrome of abnormal, involuntary movements) and the potential for it to become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic increase. The syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. Prescribing antipsychotics should be consistent with the need to minimize TD.

Discontinue ARISTADA if clinically appropriate. TD may remit, partially or completely, if antipsychotic treatment is withdrawn.

Metabolic Changes: Atypical antipsychotic drugs have been associated with metabolic changes that include:

- **Hyperglycemia/Diabetes Mellitus:** Hyperglycemia, in some cases extreme and associated with ketoacidosis, coma, or death, has been reported in patients treated with atypical antipsychotics. There have been reports of hyperglycemia in patients treated with oral aripiprazole. Patients with diabetes should be regularly monitored for worsening of glucose control; those with risk factors for diabetes should undergo baseline and periodic fasting blood glucose testing. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia, including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia should also undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients require continuation of antidiabetic treatment despite discontinuation of the suspect drug.
- **Dyslipidemia:** Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.
- **Weight Gain:** Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

Pathological Gambling and Other Compulsive Behaviors: Compulsive or uncontrollable urges to gamble have been reported with use of aripiprazole. Other compulsive urges less frequently reported include sexual urges, shopping, binge eating and other impulsive or compulsive behaviors which may result in harm for the patient and others if not recognized. Closely monitor patients and consider dose reduction or stopping aripiprazole if a patient develops such urges.

Orthostatic Hypotension: Aripiprazole may cause orthostatic hypotension which can be associated with dizziness, lightheadedness, and tachycardia. Monitor heart rate and blood pressure, and warn patients with known cardiovascular or cerebrovascular disease and risk of dehydration and syncope.

Falls: Antipsychotics including ARISTADA INITIO and ARISTADA may cause somnolence, postural hypotension or motor and sensory instability which may lead to falls and subsequent injury. Upon initiating treatment and recurrently, complete fall risk assessments as appropriate.

Leukopenia, Neutropenia, and Agranulocytosis: Leukopenia, neutropenia and agranulocytosis have been reported with antipsychotics. Monitor complete blood count in patients with pre-existing low white blood cell count (WBC)/absolute neutrophil count or history of drug-induced leukopenia/neutropenia. Discontinue ARISTADA INITIO and/or ARISTADA at the first sign of a clinically significant decline in WBC and in severely neutropenic patients.

Seizures: Use with caution in patients with a history of seizures or with conditions that lower the seizure threshold.

Potential for Cognitive and Motor Impairment: ARISTADA INITIO and ARISTADA may impair judgment, thinking, or motor skills. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are certain therapy with ARISTADA INITIO and/or ARISTADA does not affect them adversely.

Body Temperature Regulation: Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Advise patients regarding appropriate care in avoiding overheating and dehydration. Appropriate care is advised for patients who may exercise strenuously, may be exposed to extreme heat, receive concomitant medication with anticholinergic activity, or are subject to dehydration.

Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use; use caution in patients at risk for aspiration pneumonia.

Concomitant Medication: ARISTADA INITIO is only available at a single strength as a single-dose pre-filled syringe, so dosage adjustments are not possible. Avoid use in patients who are known CYP2D6 poor metabolizers or taking strong CYP3A4 inhibitors, strong CYP2D6 inhibitors, or strong CYP3A4 inducers, antihypertensive drugs or benzodiazepines.

Depending on the ARISTADA dose, adjustments may be recommended if patients are 1) known as CYP2D6 poor metabolizers and/or 2) taking strong CYP3A4 inhibitors, strong CYP2D6 inhibitors, or strong CYP3A4 inducers for greater than 2 weeks. Avoid use of ARISTADA 662 mg, 882 mg, or 1064 mg for patients taking both strong CYP3A4 inhibitors and strong CYP2D6 inhibitors. (See Table 4 in the ARISTADA full Prescribing Information.)

Commonly Observed Adverse Reactions: In pharmacokinetic studies the safety profile of ARISTADA INITIO was generally consistent with that observed for ARISTADA. The most common adverse reaction (≥5% incidence and at least twice the rate of placebo reported by patients treated with ARISTADA 441 mg and 882 mg monthly) was akathisia.

Injection-Site Reactions: In pharmacokinetic studies evaluating ARISTADA INITIO, the incidences of injection-site reactions with ARISTADA INITIO were similar to the incidence observed with ARISTADA. Injection-site reactions were reported by 4%, 5%, and 2% of patients treated with 441 mg ARISTADA (monthly), 882 mg ARISTADA (monthly), and placebo, respectively. Most of these were injection-site pain and associated with the first injection and decreased with each subsequent injection. Other injection-site reactions (induration, swelling, and redness) occurred at less than 1%.

Dystonia: Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during the first "days of treatment and at low doses.

Pregnancy/Nursing: May cause extrapyramidal and/or withdrawal symptoms in neonates with third trimester exposure. Advise patients to notify their healthcare provider of a known or suspected pregnancy. Inform patients that there is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ARISTADA INITIO and/or ARISTADA during pregnancy. Aripiprazole is present in human breast milk. The benefits of breastfeeding should be considered along with the mother's clinical need "for ARISTADA INITIO and/or ARISTADA and any potential adverse effects on the infant from ARISTADA INITIO and/or ARISTADA or from the underlying maternal condition.

Please see full Prescribing Information, including Boxed Warning, for ARISTADA INITIO and ARISTADA.

PLEASE SEE PRESCRIBING INFORMATION AND MEDICATION GUIDE FOR ARISTADA INITIO, PRESCRIBING INFORMATION AND MEDICATION GUIDE FOR ARISTADA, OR VISIT ARISTADA.COM. PLEASE REVIEW MEDICATION GUIDE WITH PATIENTS.