Noven Enrollment Form

Customer Service: 888-526-0132
Fax completed form to 877-461-0907

Care Access Network NOVEN CAN

Patient Information*

*PATIENT NAME (LAST, FIRST):

*DATE OF BIRTH (MM/DD/YYYY):

*GENDER:
☐ FEMALE ☐ MALE

*ADDRESS (CANNOT BE A PO BOX):

*CITY: *STATE: *ZIP:

*CELL: *HOME PHONE:

EMAIL:

ADDITIONAL CONTACT PHONE

* (ADDITIONAL INFORMATION MAY BE REQUIRED, INCLUDING INCOME INFORMATION FOR FURTHER VERIFICATION.)

Prescription Information

PRESCRIPTION OPTIONS	QTY (1 BOX = 30 PATCHES)	REFILLS	SIG
☐ **SECUADO® (ASENAPINE) TRANSDERMAL SYSTEM 3.8 MG/24HR** NDC: 68968-0172-3			
☐ **SECUADO® (ASENAPINE) TRANSDERMAL SYSTEM 5.7 MG/24HR** NDC: 68968-0173-3			
☐ **SECUADO® (ASENAPINE) TRANSDERMAL SYSTEM 7.6 MG/24HR** NDC: 68968-0174-3			

Primary Prescription Insurance

INSURANCE NAME: PHARMACY HELP DESK PHONE #

*POLICYHOLDER: NAME:

*RELATIONSHIP TO PATIENT

*MEMBER ID: GROUP ID:

RX BIN: PCN:

Office Contact Information

*OFFICE CONTACT NAME (LAST, FIRST):

EMAIL: PHONE:

Please see full Prescribing Information including BOXED WARNING at www.secuado.com

NOVEN

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Prescriber Information

*PRESCRIBER NAME (LAST, FIRST): NPI:

*PRESCRIBER PHONE: FAX:

ADDRESS:

*CITY: *STATE: *ZIP:

*EMAIL:

Clinical Information

PLEASE LIST ANY KNOWN ALLERGIES TO MEDICATION OR OTHER SUBSTANCES:

ICD-10 CODES

- ☐ **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

Provider Attestation

By signing below, I verify that the person listed on this form is my patient for whom I have prescribed the product identified on this form, and that this product is medically necessary.

I understand that ASPN Pharmacies, LLC ("ASPN") reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through the Noven Care Access Network (Noven C.A.N.™" or the "Program) or any of the affiliated programs administered through Noven C.A.N.™

I understand that my patient's information provided to Noven C.A.N.™, ASPN and any third parties responsible for administering this Program is to be used to verify my patient's insurance coverage; to asses, if applicable, my patient's eligibility for patient assistance and other support programs; ; and to otherwise administer Noven C.A.N.™ for the patient.

I verify that my state license number is valid and in good standing, and I agree to notify ASPN immediately in writing if the status of my state license number changes. I authorize ASPN as my designated agent to use and disclose my patient's Protected Health Information (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, as well as other state or federally protected personal information) as may be necessary for treatment, payment, and healthcare operations, including to (1) verify the accuracy of any information provided; (2) verify patient eligibility for the Program; (3) benefits verification; (4) provide for payment and reimbursement; and (5) forward prescription information to a pharmacy for fulfillment. I allow ASPN to email me regarding prescription status updates and information about submit a prior authorization request.

I understand that free product is not contingent on any purchase obligations. I also understand that no free product may be submitted for reimbursement to any payer, including Medicare and Medicaid; and no free product may be sold, traded, or distributed for sale.

I agree that this authorization is voluntary and that I may refuse to sign this authorization. I understand that I may withdraw this authorization at any time by written notification to ASPN at 200 Park Ave, Suite 300, Florham Park NJ 07932. Withdrawal of my authorization will terminate my participation in this program but will not affect information already disclosed.

I certify that I am the physician identified on this form and I certify that the medical necessity information contained in this document is true, accurate and complete to the best of my knowledge. I consent to Noven C.A.N.™ contacting me by fax, mail, or email to provide additional information about the Program, and acknowledge that Noven C.A.N.™ may revise, change, or terminate any program services at any time without notice to me.

*PRESCRIBER'S SIGNATURE: ***(DISPENSE AS WRITTEN)***

SIGNATURE IS REQUIRED TO PROCESS THE PRESCRIPTION.
STAMPED SIGNATURES ARE NOT PERMISSIBLE.

*DATE OF SIGNATURE:

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Care Access Network NOVEN CAN™

Patient Attestation

By signing below, I am enrolling in the Noven Care Access Network ("Noven C.A.N.™" or the "Program") and authorize Noven and any third parties responsible for administering this Program (together, "Program Sponsor") to provide me services under the Program. Such services may include medication and adherence communications and support, medication dispensing support, coverage and patient assistance and other support services. I affirm that the information provided in this document is complete, true and accurate to the best of my knowledge.

I authorize my health insurer, health plan(s) or programs, pharmacy providers and physicians (including their office staff) to disclose my personal information, including financial information and Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, as well as other state or federally protected personal information) (collectively, "My Information") to Noven and any third parties responsible for administering this Program (together, "Program Sponsor"). PHI includes information about my insurance, prescription, medical condition and health. I understand that My Information will be used by the Program Sponsor for purposes of (1) determining my eligibility to participate in Noven C.A.N.™ coverage assistance programs, patient assistance programs, or other support programs; (2) operating and administering the program; (3) sending me information about the program; (4) verifying my insurance benefits; (5) obtaining prior authorization for coverage; (6) to assist with appeals of denied claims for coverage; (7) to refer me to, or to determine my eligibility for, other programs, foundations, or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my prescription; and (8) contacting me, my legal guardian (if applicable), my doctor/healthcare provider, their office/staff, my insurer or others about my medical care, as necessary.

I agree to receive phone calls, text messages, emails and materials from the Program Sponsor at the numbers and locations provided on this form.

I authorize and consent to the disclosure by Program Sponsor of My Information as required or permitted by law. I understand that my information will be kept confidential and will not be further used or disclosed except to administer the program, or as required by law. I understand that My Information disclosed under this authorization may be re-disclosed and is no longer protected by federal privacy regulations.

I agree that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment from my doctor/healthcare provider but I will not be able to participate in this program. Unless revoked, this authorization shall remain in effect throughout my participation in the program, including subsequent reapplication as required. I understand that I may request a copy of this Authorization.

I understand that I may withdraw this authorization at any time by written notification to ASPN at 200 Park Ave, Suite 300, Florham Park NJ 07932. Withdrawal of my authorization will terminate my participation in this program but will not affect information already disclosed.

I authorize the Program, and Program administrators to contact my legal guardian (if applicable) with follow up questions about my application.
I understand that:

- Completing this enrollment form does not guarantee that I will qualify for the Program.
- Noven may verify the accuracy of the information I have provided and may ask for more financial and insurance information;
- Any products supplied by the Program shall not be sold, traded, bartered or transferred;
- Noven reserves the right to change or cancel the Program, or terminate my enrollment, at any time;
- I can withdraw from the Program at any time and cancel my permission to use my information; and
- Any assistance and support provided under this Program is not contingent on any purchase obligations.

I certify and attest that if I receive product(s) provided by Noven through the Program:

- I will promptly contact the Program if my financial status or insurance coverage changes.
- I will not seek reimbursement or credit for the product from my prescription insurance provider or payor, including Medicare Part D plans for any costs of products or count the product or its cost toward my out-of-pocket expenses for any prescription insurance provider or payor.
- I will notify my insurance provider of the receipt of any products through the Program.

*PATIENT'S SIGNATURE:

Please see full Prescribing Information including BOXED WARNING at www.secuado.com

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