UCB, Inc. – 1950 Lake Park Drive – Smyrna, Georgia 30080

Thank you for your interest in the UCB, Inc. Patient Assistance Program.

Product(s) covered by program:
Keppra® *(levetiracetam) 250 mg, 500 mg, 750 mg, 1000 mg tablets, and 100 mg/ml oral solution* (max dose: 3000 mg daily)

Neupro® (*Rotigotine Transdermal System*) *2 mg/24 hours, 4 mg/24 hours, 6 mg/24 hours* (max dose: 6 mg/24 hours)

Parcopa® *(carbidopa-levodopa orally disintegrating tablets) 10/100 mg, 25/100 mg, and 25/250 mg oral tablets* (max dose: 10/100, a total daily dose of 80 mg carbidopa and 800 mg levodopa; 25/100, a total daily dose of 200 mg carbidopa and 800 mg levodopa; 25/250, a total daily dose of 200 mg carbidopa and 2000 mg levodopa).

Program information:
- The UCB, Inc. Patient Assistance Program is intended to provide free prescription medication to patients who do not qualify for or have benefits through private insurance or a government funded program, and do not have other sufficient means to pay for their medication.
- Only applications that certify that the product is being prescribed for the FDA-approved indication will be accepted. The program will not supply quantities in excess of the maximum approved daily dose.
- Patients who meet the eligibility criteria of the program are provided a six-month supply of medication free of charge.
- Complete re-application is required every six months for continuing need.

Patient Eligibility Criteria (patient must meet all of the criteria):
- Patient must not have prescription drug coverage.
- Patient must not have or be eligible for Medicaid benefits.
- Patient must not receive prescription benefits from Medicare Part D.
- Patient must not have household income that exceeds $15,000 per year for an individual, or $25,000 per year with dependents.
- Patient must be a legal resident of the U.S.
- Program provisions are subject to change without notice.

Application Process:
- The patient is required to complete section one of the enclosed application.
- The application must **include a copy of the patient's W-2 forms or other proof of income.**
- The physician is required to complete section two of the enclosed application.
- The physician must **provide an original signed prescription** for a six-month supply.
- Upon approval, medication will be shipped directly to the physician for dispensing.
- Please allow **four to six weeks** for applications to be reviewed and medication to be shipped.

Patients should forward applications to:
UCB, Inc.
Patient Assistance Program
1950 Lake Park Drive
Smyrna, Georgia 30080

For further assistance, please contact the UCB, Inc. Customer Service Department at (800) 477-7877, option 7.

U Neupro® (Rotigotine Transdermal System) Patient Assistance Program Application

SECTION 1 — 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 #: - - HICN:

Gross Monthly Household Income of Applicant (Attach Documentation):

Salary/Wages/Dividends	$ .00	Pension/Annuity	$ .00
Social Security	$ .00	Alimony/Child Support	$ .00
Disability	$ .00	Other: _____	$ .00
Unemployment Compensation	$ .00	**TOTAL/MONTH**	$ .00

U.S. Resident ☐ Yes ☐ No Sex: ☐ Male ☐ Female ☐ Unknown

Number of persons DEPENDENT upon primary income within family: ☐☐

Do you currently have prescription drug coverage? ☐ Yes ☐ No

Are you currently enrolled in Medicare Part D? ☐ Yes ☐ No

If enrolled in Medicare Part D:
Please indicate drug plan (PDP) name, address, & phone number

_____

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I herby certify that the above information is correct and complete. I authorize UCB, Inc. (UCB) to review the medical and financial information provided. I also authorize UCB 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 payor. I understand UCB has the right to revise, change, or terminate the Neupro® Patient Assistance Program at any time.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____

DATE: / /

SECTION 2 — This section to be completed by the *Attending Physician*

Physician's Name:		State Lic./Authorization # & Exp. Date	
Address:		Phone #:	
City:	State:	Zip Code:	

Diagnosis and/or Diagnostic Code(s):

I hereby certify that the above named person is my patient and the medications received from UCB for the Neupro® 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 has the right to revise, change, or terminate the Neupro® Patient Assistance Program at any time.

SIGNATURE OF PHYSICIAN	**DATE:**

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Neupro® (Rotigotine Transdermal System) Patient Assistance Program Application Instructions

SECTION 1 *Patient (or Legal Guardian)*

Please complete the Application on the reverse side. *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 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.

SECTION 2 *Attending Physician*

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

Call 1-800-477-7877 extension 7 if you have questions or need assistance.
UCB, INC. reserves the right to change the provisions of this program at any time.

UCB, INC.
Neupro® Patient Assistance Program
1950 Lake Park Drive • Smyrna, GA 30080