CAPLYTA
(lumateperone) capsules

CAPLYTA Savings Card Reimbursement Form

Please print all information and mail or fax all required materials to:
CAPLYTA Claims Processing Department
PO Box 2355 - Morristown, NJ 07962
Fax: 908.809.6249

If your mail-order pharmacy or pharmacy does not accept your savings card, you can mail in the necessary information to receive your savings. Once we receive your completed claim form, we will mail you the check for your savings card reimbursement. You should receive it within 6 to 8 weeks.*

Print out and complete this form, and mail or fax it with the following items:

- Copy of your commercial Rx insurance card (front and back)
- Valid Pharmacy Invoice and proper postage

*Savings card reimbursement check amounts will vary according to quantity filled and personal healthcare insurance coverage. **Payment of the reimbursement is subject to verification** and pursuant to the terms and conditions of the Savings Card Program. See savings card for details.

Patient Information — please print

First Name ______________________ Middle ______ Last Name ______________________

Address 1 ______________________ Address 2 ______________________

City ______________________ State ________ Zip ______________________

Phone ______________________ Email ______________________

DOB ______________________ Age ______________________ Gender ______________________

Savings Card Group# (located on the front of the savings card) ______________________

Savings Card Member ID# (located on the front of the savings card) ______________________

Prescriber Information — please print

First Name ______________________ Middle ______ Last Name ______________________

Address 1 ______________________ Address 2 ______________________

City ______________________ State ________ Zip ______________________

Phone ______________________

Your completed reimbursement form must be accompanied by a dated Pharmacy Invoice with product information (proof of purchase) with the amount of copayment or out-of-pocket expenses highlighted. Cash register receipts are not eligible.

Forms submitted without a Pharmacy Invoice will not be valid and therefore will not be eligible to receive reimbursement.

I, ______________________, certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the copayment or out-of-pocket expenses requested for reimbursement were incurred. **By seeking reimbursement, I am consenting to sharing my personal information and having it be used for processing purposes.**

Patient or Legal Guardian signature ______________________

For additional questions, please call 1-800-639-4047.

CAPLYTA is available in 10.5 mg, 21 mg, or 42 mg capsules.

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Intra-Cellular THERAPIES