GOCOVRI® (amantadine) extended release capsules

PRESCRIPTION FORM

Fax completed form to: **1-844-826-7626**.
For assistance, please call: **844-GOCOVRI (844-462-6874)**.

INCLUDING OPTIONAL 4-WEEK FREE TRIAL

1 PATIENT INFORMATION

Patient signature required in Section 4 or on page 2.

First Name | Last Name

Gender ☐ Male ☐ Female
US Resident ☐ Yes ☐ No

Date of Birth (MM/DD/YYYY)

Address | Unit | City

State | ZIP | Mobile Phone

Additional Phone Number | Email

Alternate Contact

Alternate Contact Phone Number | Relationship to Patient

Language Preference: ☐ English ☐ Spanish ☐ Other

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

☐ I authorize GOCOVRI ONBOARD® to leave a message, including the prescription name GOCOVRI®.

☐ I authorize an alternate contact to speak on patient's behalf.

2 INSURANCE INFORMATION

Please attach a copy of both sides of the patient's insurance card(s).

☐ **No prescription (Rx) insurance**

Primary Medical Insurance | Insurance Phone Number

Group # | ID #

Prescription Insurance | RxGroup

Prescription Name

RxBIN | RxPCN

3 CLINICAL INFORMATION

Is patient new to GOCOVRI? ☐ Yes ☐ No

Please confirm diagnosis:

☐ Parkinson's disease *without* dyskinesia, with fluctuations **(ICD-10: G20.A2)**

☐ Parkinson's disease with dyskinesia, without mention of fluctuations **(ICD-10: G20.B1)**

☐ Parkinson's disease with dyskinesia, with fluctuations **(ICD-10: G20.B2)**

☐ Other

4 PATIENT SIGNATURES (REQUIRED)

I have read and agreed to the Patient Authorization on page 2

SIGN HERE | Patient Signature | Date

Initials denote I agree to Free Trial Program Terms and Conditions.

Initial here

5 PRESCRIBER INFORMATION

Prescriber Full Name | Office/Institution Name

Prescriber NPI # | Medicaid Provider ID #

Address | Suite | City

State | ZIP | Phone Number

Email | Fax

Office Contact Name

For NEW patients only. Complete EITHER step 6 for Free Trial OR step 7 for Initial Rx.

6 GOCOVRI® 4-WEEK FREE TRIAL PROGRAM (OPTIONAL)

I authorize the GOCOVRI® Free Trial Program Pharmacy to dispense a free, one-time, 4-week supply of GOCOVRI®. There is no purchase obligation to participate in the Free Trial Program. This program is optional. By signing below, I agree to Free Trial Program Terms and Conditions on page 2.

Was patient previously provided a Free Sample of GOCOVRI®? ☐ Yes ☐ No

If a patient has received a sample of GOCOVRI®, they are NOT eligible for the Free Trial program.

☐ **GOCOVRI® 68.5 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (137 mg) PO QHS. Dispense 49 caps. **No refills.**

☐ **GOCOVRI® 137 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (274 mg) PO QHS. Dispense 49 caps. **No refills.**

☐ **GOCOVRI®** ____ **mg**. Take ____ cap(s) PO QHS x ____ days; then ____ cap(s) (____ mg) PO QHS. Dispense ____ caps. **No refills.**

7 GOCOVRI INITIAL PRESCRIPTION FOR FIRST MONTH

☐ **GOCOVRI® 68.5 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (137 mg) PO QHS. Dispense 49 caps. **No refills.**

☐ **GOCOVRI® 137 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (274 mg) PO QHS. Dispense 49 caps. **No refills.**

☐ **GOCOVRI®** ____ **mg**. Take ____ cap(s) PO QHS x ____ days; then ____ cap(s) (____ mg) PO QHS. Dispense ____ caps. **No refills.**

For ALL Patients. Proceed to step 8 to complete Maintenance Rx.

8 MAINTENANCE PRESCRIPTION (FOR ALL PATIENTS)

☐ **GOCOVRI® 68.5 mg**. Take 2 caps (137 mg) PO QHS. Dispense 60 caps. Number of refills ____

☐ **GOCOVRI® 137 mg**. Take 2 caps (274 mg) PO QHS. Dispense 60 caps. Number of refills ____

☐ **GOCOVRI®** ____ **mg**. Take ____ cap(s) (____ mg) PO QHS. Dispense ____ caps. Number of refills ____

9 PRESCRIBER SIGNATURE (ORIGINAL SIGNATURE REQUIRED)

I certify that the information provided in this GOCOVRI® Prescription Form is complete and accurate to the best of my knowledge. I have prescribed GOCOVRI® based on my judgment of medical necessity. I certify that I have obtained my patient's authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Supernus Pharmaceuticals and GOCOVRI ONBOARD for benefits eligibility, coverage authorization, coordination and dispensing of GOCOVRI®, and providing me and my patient with other educational and support services associated with GOCOVRI®. I agree that the GOCOVRI ONBOARD program may contact me for additional information related to GOCOVRI, including but not limited to via email, fax, and telephone. PLEASE SIGN ONE OF THE TWO BELOW.

SIGN HERE | Date

OR **Dispense As Written/DAW**

SIGN HERE | Date

Substitution Permissible

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____

ATTN: New York and Iowa providers, please submit electronic prescription

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(amantadine) extended release capsules

PATIENT AUTHORIZATION AND CONSENT FORM (OPT-IN)

Fax completed form to: **1-844-826-7626**.
For assistance, please call: **844-GOCOVRI (844-462-6874)**.

INCLUDING OPTIONAL 4-WEEK FREE TRIAL

PRESCRIPTION FORM PATIENT AUTHORIZATION

I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") and each of their respective representatives, employees, and agents (collectively "Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details (Protected Health Information "PHI") to Supernus, and companies working with Supernus, which may be branded as GOCOVRI ONBOARD® (collectively, "Supernus") for Supernus to (i) provide me with support services and related information and materials on any of Supernus' products, including, but not limited to, educational support provided in person, online or by telephone, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided, and (iii) provide me with information about Supernus' products, services, and programs and other topics of interest for marketing, educational or other purposes.

For purposes of clarification, Supernus includes but is not limited to brand specific support through specialty pharmacy service providers, as well as other entities under contract with Supernus, to support these or similar aspects of the Services.

Once my health information has been disclosed to Supernus, I understand that federal privacy laws no longer protect the information. However, Supernus agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations.

I understand that my pharmacy provider may receive remuneration from Supernus in exchange for the health information and/or for any support services provided to me.

I understand that I am not required to sign this Authorization and that my Healthcare Entities will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. This Authorization will expire in 10 years or a shorter period if required by state law, unless I revoke it sooner by calling 1-844-462-6874 or writing GOCOVRI ONBOARD Supernus, c/o 130 Enterprise Drive, Pittsburgh, PA 15275.

I understand that revoking my Authorization will not affect any use of my information that occurred before my request was processed. I am entitled to a copy of this signed authorization.

FREE TRIAL PROGRAM TERMS AND CONDITIONS

The Free Trial Program provides eligible patients with a 28-day supply of GOCOVRI®. There is no purchase obligation to participate in the Free Trial Program. This Program is only for patients who are new to treatment and have an on-label prescription. Patients who elect to discontinue GOCOVRI® treatment after the Free Trial may be eligible to receive an additional 7-day supply of GOCOVRI® at a lower dose. Supernus reserves the right to modify or cancel this Program without notice at any time.

Patient: I certify that I will not seek reimbursement or credit for my Free Trial prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I certify that I have never used GOCOVRI® before, including receiving a physical sample from my doctor.

Prescriber: By signing on page 1, I certify that this prescription is on label and the patient has not yet started GOCOVRI® treatment. I agree that I will not seek reimbursement from any government program or third-party insurer for any medication dispensed to the patient through the Free Trial Program. I certify that I have never prescribed or given GOCOVRI® to this patient before, including the provision of a physical sample from my office.

10 PATIENT SIGNATURES (REQUIRED)

I have read and agree to the Patient Authorization above

SIGN HERE

Patient Signature | **Date** | **Initial here**

Initials denote I agree to Free Trial Program Terms and Conditions.

(Patient signature and date are required for services)

First Name | **Last Name** | **Date of Birth (MM/DD/YYYY)** | **Preferred Phone Number**

PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.

Supernus® Pharmaceuticals

GOCOVRI ONBOARD support focused on you

GOCOVRI®
(amantadine) extended release capsules

PATIENT AUTHORIZATION AND CONSENT FORM (OPT-IN) PATIENT COPY

PRESCRIPTION FORM PATIENT AUTHORIZATION

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") and each of their respective representatives, employees, and agents (collectively "Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details (Protected Health Information "PHI") to Supernus, and companies working with Supernus, which may be branded as GOCOVRI ONBOARD® (collectively, "Supernus") for Supernus to (i) provide me with support services and related information and materials on any of Supernus' products, including, but not limited to, educational support provided in person, online or by telephone, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided, and (iii) provide me with information about Supernus' products, services, and programs and other topics of interest for marketing, educational or other purposes.

For purposes of clarification, Supernus includes but is not limited to brand specific support through specialty pharmacy service providers, as well as other entities under contract with Supernus, to support these or similar aspects of the Services.

Once my health information has been disclosed to Supernus, I understand that federal privacy laws no longer protect the information. However, Supernus agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations.

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I understand that I am not required to sign this Authorization and that my Healthcare Entities will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. This Authorization will expire in 10 years or a shorter period if required by state law, unless I revoke it sooner by calling 1-844-462-6874 or writing GOCOVRI ONBOARD Supernus, c/o 130 Enterprise Drive, Pittsburgh, PA 15275.

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I have read and understand the Patient Authorization above and agree to the terms.

Please see the Important Safety Information on the back of this page.

GOCOVRI®
(amantadine) extended release capsules

WHAT IS GOCOVRI?

GOCOVRI® (amantadine) extended release capsules is a prescription medicine used:

- for the treatment of dyskinesia (sudden uncontrolled movements) in people with Parkinson's disease who are treated with levodopa therapy or levodopa therapy with other medicines that increase the effects of dopamine in the brain.
- with levodopa and carbidopa in people with Parkinson's disease who are having "off" episodes.

It is not known if GOCOVRI is safe and effective in children.

IMPORTANT SAFETY INFORMATION

DO NOT take GOCOVRI if you have severe kidney problems.

WHAT SHOULD I AVOID WHILE TAKING GOCOVRI?

Do not stop or change the dose of GOCOVRI before talking with your doctor. Call your healthcare provider if you have symptoms of withdrawal such as fever, confusion, or severe muscle stiffness.

Do not drink alcohol while taking GOCOVRI as it can increase your chances of serious side effects.

Do not drive, operate machinery, or do other dangerous activities until you know how GOCOVRI affects you.

If you took too much GOCOVRI, call your doctor or go to the nearest hospital emergency room right away.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF GOCOVRI?

- **Falling asleep during normal activities.** Activities may include driving, talking, or eating. You may fall asleep without being drowsy or warning.
- **Suicidal thoughts or actions and depression.** Tell your doctor if you have new or sudden changes in mood, behaviors, thoughts, or feelings, including thoughts about hurting yourself or ending your life.
- **Hallucinations.** GOCOVRI can cause or worsen hallucinations (seeing or hearing things that are not real) or psychotic behavior.
- **Feeling dizzy, faint or lightheaded,** especially when you stand up (orthostatic hypotension). Lightheadedness or fainting may happen when getting up too quickly after long periods of time, when first starting GOCOVRI, or if your dose has been increased.
- **Unusual urges.** Examples include gambling, sexual urges, spending money, binge eating, and the inability to control them.

The most common side effects of GOCOVRI include dry mouth, swelling of legs and feet, constipation, and falls. If you or your family notices that you are developing any new, unusual or sudden changes in behavior or related symptoms, tell your healthcare provider right away.

These are not all the possible side effects of GOCOVRI. Call your doctor for medical advice about side effects.
You may report side effects to FDA at 1-800-FDA-1088.

TELL YOUR DOCTOR ABOUT ALL MEDICAL CONDITIONS, INCLUDING IF YOU:

- have kidney problems.
- have unexpected or unpredictable sleepiness, sleep disorders, or currently take medication to help you sleep or make you drowsy.
- are pregnant or plan to become pregnant or are breastfeeding or plan to breastfeed. GOCOVRI may harm your unborn baby and can pass into your breastmilk.

Tell your doctor about all the medicines you take. Include prescription and over-the-counter medicines, vitamins, and herbal supplements.

Especially tell your doctor if you take medicines like sodium bicarbonate, or have had or are planning to have a live flu vaccination (nasal spray). You can receive the flu vaccination shot but should not get a live flu vaccine while taking GOCOVRI.

Please refer to the full Prescribing Information and Patient Information or visit Gocovri.com.

Supernus® Pharmaceuticals

GOCOVRI ONBOARD® support focused on you

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GOCOVRI ONBOARD® support focused on you

GET PATIENTS STARTED ON GOCOVRI® WITH THESE QUICK STEPS

GOCOVRI Onboard® partners with a Specialty Pharmacy to provide ONE direct line of contact and ensure timely fulfillment

YOU ARE HERE

1. Fill out, sign, and fax the Prescription Form to GOCOVRI Onboard® at 1-844-826-7626
   - Be sure to complete the Prescription Form before your patient leaves the office

2. A benefits verification is initiated

3. If a Prior Authorization (PA) is required, GOCOVRI Onboard® will initiate the PA and send to your office via CoverMyMeds
   - GOCOVRI Onboard® may reach out to you to ensure timely completion

4. The Specialty Pharmacy will call your patient to schedule next-day delivery of GOCOVRI®
   Note: your patients will need to speak with the Specialty Pharmacy over the phone in order to schedule their first delivery
   - If the Specialty Pharmacy is not able to reach the patient, they may reach out to you to help facilitate contact

5. The Specialty Pharmacy will follow up monthly to schedule recurring deliveries

Scan this code to save the Specialty Pharmacy contact info to your phone