APOKYN® (apomorphine hydrochloride injection) Prescription Form for VA Patients

Forward completed form to the VA Pharmacy. The VA Pharmacy will fax completed form to Accredo at 1- 800-464-2107

Please complete all fields to avoid delays in processing.

Phone: 1-800-258-2231
DUNS#: 363066452

VA PATIENT INFORMATION

First name: Gender: ☐ M ☐ F	Address:
Middle initial and last name:	City: State ZIP:
DOB:	Email:
Home phone:	Preferred language other than English:
Cell Phone/Other:	Authorized representative:
Preferred number: ☐ Home ☐ Mobile ☐ OK to leave message	Relationship to patient:
Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening	Phone number (authorized representative): ☐ OK to leave message

☐ Check here for delivery directly to patient's shipping address listed above. If information is incomplete, the prescription will be shipped to the VA pharmacy listed below.

VA PHARMACY INFORMATION

VA name:	Payment method: ☐ Credit card (call pharmacy contact) ☐ E-Invoice Tungsten Network
Address:	
City: State: ZIP:	Purchase order #:
Primary purchasing contact:	Secondary purchasing contact:
Phone: Fax:	Phone: Fax:
Email:	Email:
Primary clinical contact:	Secondary clinical contact:
Phone: Fax:	Phone: Fax:
Email:	Email:

PRESCRIBER INFORMATION

Today's date:	
Prescriber name:	Address:
License #: or NPI #	City: State: ZIP:
Office contact name:	Email:
Office contact phone:	Phone: Fax:

DIAGNOSIS

Diagnosis (ICD-10): ☐ ICD-10: G20.A2 *(Parkinson's Disease without dyskinesia, with fluctuations)* ☐ ICD-10: G20.B2 *(Parkinson's Disease with dyskinesia, with fluctuations)* ☐ Other: ____________________

APOKYN® (apomorphine hydrochloride injection) PRESCRIPTION INFORMATION

Check Initiation Prescription or Maintenance Prescription

APOKYN Initiation Prescription

☐ **Rx APOKYN 3 mL Cartridges – Administer doses as directed**

- One box of five 3 mL cartridges. Sig: Under medical supervision, initially inject 0.2 mL
- Titrate by 0.1 mL as directed by physician at initiation, every few days, and as needed per patient response until patient reaches maximum tolerated dose or to a max dose of 0.6 mL per OFF episode
- One APOKYN Pen Pack (includes one pen device and pen needles). Sig: Under medical supervision, use to administer APOKYN
- One box of 100 BD Ultra-Fine™ pen needles 29 g x ½ in. Sig: Use with APOKYN pen
- One 1.5 quart Sharps Container. Sig: Use to dispose of pen needles

APOKYN Maintenance Prescription

☐ **APOKYN 3 mL Cartridges**

Sig: Inject ______ mL (dose) subcutaneously, ______ times (doses) per day
Maximum 5 times (doses)/day

Days supply: ☐ **30 day** ☐ **90 day** ☐ **Other** **Refills:**_____________

- Titrate by 0.1 mL as directed by physician at initiation, every few days, and as needed per patient response until patient reaches maximum tolerated dose or to a max dose of 0.6 mL per OFF episode

☐ **BD Ultra-Fine™ pen needles 29 g x ½ in**

Days supply: ☐ **30 day** ☐ **90 day** ☐ **Other** **Refills:**_____________

- Quantity: Box of 100, use to administer APOKYN

Clinical Information:

☐ No Known Drug Allergies

Please list all drug and non-drug allergies: ____________________

Concomitant medications: ____________________

IMPORTANT: If complementary in-home initiation support and education by the Supernus® Circle of Care™ Clinical Educator is requested by the patient, a copy of this prescription form must also be faxed to the Supernus HUB at 1-888-525-2431.

I authorize the VA Pharmacy to act on my behalf for the purpose of transmitting this prescription to Accredo for the purpose of processing and dispensing this prescribed medication for my patient.

>> **Prescriber Signature** ____________ *(Dispense as written)*	>> **Prescriber Signature** ____________ *(Substitutions permitted)*
Date (MM/DD/YYYY):	**Date (MM/DD/YYYY):**

Original signature required. Signature stamp not acceptable.

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