FAX this page

Prescription and Enrollment Form

Phone: 1-877-727-6596 Fax: 1-888-525-2431

Patient Information

First Name: ______ MI: ______ Last Name: ______ DOB: ______ Gender: ☐ M ☐ F

Address: ______ City: ______ State: ______ ZIP: ______

Primary Phone: ______ ☐ Home ☐ Cell Email: ______

Language Preference: ☐ English ☐ Spanish ☐ Other: ______

Best time to contact: ☐ Morning ☐ Afternoon Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

Alternate Contact Name: ______ Phone: ______ Relationship to Patient: ______

I authorize Circle of Care to leave a detailed message, including the prescription name APOKYN. ☐ Yes ☐ No

Medical Insurance Information (Attach copies of both sides of card)

☐ Policyholder same as patient

Policyholder Name: ______

Primary Insurance: ______ Phone: ______

Primary ID: ______ Group ID: ______

Secondary ID: ______ Group ID: ______

Pharmacy Benefit Information (Located on the ID card; separate card for Part D) Attach copies of both sides of patient's pharmacy benefit card(s)

Pharmacy ID: ______ Rx BIN: ______

Rx PCN: ______ Rx GRP: ______

☐ **Check if no insurance** ☐ **Enroll in copay assistance if commercially insured**

Prescriber Information

First Name: ______ Last Name: ______

Practice Name: ______

Address: ______

City: ______ State: ______ ZIP: ______

Phone: ______ Fax: ______

NPI #: ______

Physician State License #: ______

Office Contact Name: ______

Preferred Phone & Email: ______

APOKYN Prescription: 30 mg/3 mL (10 mg/mL) Cartridges

Please Confirm Diagnosis: ☐ **ICD-10: G20 Parkinson's Disease** ☐ **Other:** ______

☐ APOKYN INITIATION PRESCRIPTION *(For NEW Patients Only)*

Under medical supervision inject subcutaneously:

(select a start dose) ☐ 0.1 mL ☐ 0.2 mL

Quantity: 14-day supply, **no refills** for Initiation Prescription

Use as needed, doses must be separated by at least 2 hours

Initiation Prescription Dispense:

- Ten (10) 3 mL cartridges of APOKYN
- One (1) box of 100 BD Ultra-Fine™ pen needles 29G x ½ inch
  If other needles are desired, a separate prescription is required
- One (1) APOKYN Pen Pak (single pen device and pen needles)
- One (1) 1.5 quart sharps container
- Two hundred (200) alcohol swabs

☐ APOKYN MAINTENANCE PRESCRIPTION *(For REFILLS Only)*

Inject ______ mL (dose) subcutaneously, ______ times (doses) per day

Maximum 5 times (doses)/day

☐ 30-day supply ☐ 90-day supply ☐ Other: ______ # of Refills: ______

Maintenance Prescription Dispense:

- Two (2) boxes of 100 BD Ultra-Fine™ pen needles 29G x ½ inch
  If other needles are desired, a separate prescription is required
- One (1) 1.5 quart sharps container
- Two hundred (200) alcohol swabs

Additional APOKYN Pen Paks for Maintenance Prescriptions

☐ 1 Pen Pak, # of Refills: ______

☐ 2 Pen Paks, # of Refills: ______

Titration Orders: The recommended starting test dose of APOKYN is 0.1 mL to 0.2 mL • Dose escalation procedures, as per full Prescribing Information protocol, under medical supervision • 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 max dose of 0.6 mL per OFF episode. *Other Titration Instructions:* ______

- Follow guidelines per the APOKYN Pen Instructions for Use: Estimated priming volume is 0.3-0.4 mL for a new cartridge, then 0.1 mL per dose thereafter
- Note to SP: Refer to APOKYN Cartridge Calculation Guide at APOKYNHCP.com for guidance in determining the appropriate number of cartridges

Prescriber Signature and Date — No Stamps

SIGN HERE

______ **OR** ______

Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Date**

May Substitute / Product Selection Permitted / Substitution Permissible **Date**

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

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

I certify that the information provided in this APOKYN Prescription Form is complete and accurate to the best of my knowledge. I have prescribed APOKYN based on my judgment of medical necessity. I certify that I have obtained my patient's written 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 to the Circle of Care™ program for benefits eligibility, coverage authorization, coordination and dispensing of APOKYN, and providing me and my patient with other educational and support services associated with APOKYN. I agree that the Circle of Care program may contact me for additional information relating to APOKYN, including but not limited to via email, fax, and telephone. I authorize the Circle of Care program to transmit the above prescription to the pharmacy.

Prescribers must sign for the prescription above and for the Circle of Care Clinical Education Services on page 3 and fax pages 1, 2 and 3 to: 1-888-525-2431.

NP.APO.2022-0027 01/23

FAX this page

Prescription and Enrollment Form

Patient Name: **DOB:**

Circle of Care™ Clinical Education Services

Patient will be enrolled in the Circle of Care Clinical Education Program as described below:

- **Pre-Initiation Patient Support and Education:** Clinical Educator schedules and provides education to patient on APOKYN. Initiation preparation steps include instructing patient to withhold the last dose of Parkinson's medications (oral carbidopa/levodopa) prior to the initiation appointment. If an antiemetic is prescribed, the patient will be educated to administer per physician's order. The Pre-Initiation Education may be conducted in person or by telephone or video conference.
- **Initiation Services for Patients:** Clinical Educator schedules, coordinates and educates patient on how to administer APOKYN and monitors the patient's response to APOKYN. Initiation services may be conducted in office or in home.
- **Post-Initiation Support and Education:** Clinical Educator schedules, coordinates and provides post-initiation education to patient and updates prescriber, as needed. Services may be conducted in person or by telephone or video conference.
- **Dose Titration Orders:** Clinical Educator may teach the patient and/or care partner, in home or in office, on titrating the APOKYN dose per the Titration Orders.

The initiation will occur: ☐ **Office** ☐ **Home** ☐ **Other:** ______________________

Clinical Educator Opt-Out (optional):

☐ No, my staff will conduct the initiation, but a Clinical Educator may be used for Pre- and Post-Initiation Support and Education

☐ No, my staff will conduct the initiation as well as Pre- and Post-Initiation Support and Education

Prescriber Declaration: I certify that (a) any service provided through the Circle of Care program on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe or use APOKYN or any other Supernus product or service for anyone, and (b) my decision to prescribe APOKYN was based on my determination of medical necessity as set forth herein. I acknowledge that I cannot bill for services rendered by the Circle of Care program.

I authorize the Circle of Care program to be my designated agent (1) to provide any information on this form to the insurer of the named patient, and (2) to act on my behalf for the purpose of transmitting this prescription and the information to the appropriate dispensing specialty pharmacy designated by the patient utilizing their benefit plan.

SIGN HERE ______________________ **Prescriber Signature** ______________________ **Date**

Prescribers must sign above for the Circle of Care Clinical Education Services and fax with the signed Prescription Form (page 2), and page 1, to: 1-888-525-2431. Please ensure that patient reads and signs page 1, Patient Authorization and Consent.

NP.APO.2022-0027 01/23