FAX this page

Patient Authorization and Consent

APOKYN® apomorphine hydrochloride injection

Patient Name: **DOB:**

Please read the following carefully, then sign and date below.

I. Patient Services Authorization and Release of Health Information Form

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 Circle of Care™ (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 a hub service provider, specialty pharmacy service providers, Clinical Educators, 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 writing Circle of Care/Supernus, c/o PharmaCord, PO Box 5490, Louisville, KY 40255. 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.

I have read and understand the Authorization to Share Health Information for Patient Support Services and agree to the terms. A signature is required in order to receive Supernus services.

SIGN HERE _____ _____

Signature of patient Date

In addition, I authorize the disclosure of my health information to the following designated individual(s) (optional):

_____ _____

Designated individual (print name) Relationship

II. Marketing/Other Communications (optional)

I further authorize Supernus, and companies working with Supernus, any of which may be branded as Circle of Care (collectively "Supernus"), to contact me by mail, email, fax, telephone call, and text message for marketing purposes or otherwise provide me with information about Supernus' products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Supernus to help develop new products, services, and programs. Note that Supernus will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission.

I have read and understand the Marketing/Other Communications and agree to the terms.

SIGN HERE _____ _____

Signature of patient or designated individual Date

_____ _____

Designated individual (print name) Relationship

NP.APO.2022-0027 V2 11/23

Fax pages 1, 2, and 3 to: 1-888-525-2431.

Please provide page 4, Patient Authorization and Consent and Important Safety Information, to the patient.

FAX this page

Prescription and Enrollment Form

APOKYN® apomorphine hydrochloride injection

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 V2 11/23

I. Patient Services Authorization and Release of Health Information Form

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 Circle of Care™ (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 a hub service provider, specialty pharmacy service providers, Clinical Educators, 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 writing Circle of Care/Supernus, c/o PharmaCord, PO Box 5490, Louisville, KY 40255. 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.

I have read and understand the Authorization to Share Health Information for Patient Support Services and agree to the terms. A signature is required in order to receive Supernus services.

II. Marketing/Other Communications (optional)

I further authorize Supernus, and companies working with Supernus, any of which may be branded as Circle of Care (collectively "Supernus"), to contact me by mail, email, fax, telephone call, and text message for marketing purposes or otherwise provide me with information about Supernus' products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Supernus to help develop new products, services, and programs. Note that Supernus will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission.

I have read and understand the Marketing/Other Communications and agree to the terms.

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