Fax this page

HIPAA Authorization & Patient Services Consent for VA Patients

APOKYN® apomorphine hydrochloride injection

Complete these forms if you are electing Circle of Care™ services

PRINT HERE Patient Name: _____ Phone #: _____

Please read the following. If you agree, please sign and date the corresponding section below. This document is a legal document and as such, consent must be given by the patient or the patient's legal representative. A patient should sign their own name. If the patient is unable to sign and the document is signed by a legal representative of the patient, the legal representative should sign their own name and attach proof of patient representation such as a Power of Attorney or other legal document.

I. Authorization to Share Health Information

By signing this Authorization, I authorize my healthcare provider, Veterans Health Administration (VHA), and my pharmacy providers ("Healthcare Entities") to disclose to Supernus, and companies working with Supernus, which may be branded as Circle of Care™ (collectively, "Supernus"), my contact information, health information relating to my medical condition to the extent necessary to support treatment that may also include identifying any potential drug interactions evaluation and allergies, and insurance coverage for Supernus to (i) provide me with support services (which may be branded as Circle of Care™) and related information and materials on APOKYN, including 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 evaluating the services provided, and (iii) provide me with information about Supernus products, services, and programs and other topics of interest for educational or other purposes. Once my health information has been disclosed to Supernus, I understand that Federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Supernus. However, Supernus agrees to protect my health information by using and disclosing it only for purposes authorized in this Patient Authorization and Consent or as required by law or regulations.

I understand that my pharmacy provider may receive remuneration from Supernus in exchange for sharing information concerning any services that the pharmacy may provide to me.

I understand that I may refuse to sign this Authorization, and I further understand that my treatment (including with a Supernus product), payment for treatment, or eligibility for VHA benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign this Authorization, or later cancel it, I will not be able to receive any support services from Supernus including those branded as Circle of Care™.

I may cancel this Authorization at any time by mailing a letter to: Circle of Care/Supernus, c/o PharmaCord, PO Box 5490, Louisville, KY 40255. Canceling this Authorization will end my consent to further disclose health information to Supernus by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires ten (10) years from the day I sign it as indicated by the date next to my signature or upon earlier date as may be mandated by state law, if applicable.

II. Consent to Contact for Patient Services and Other Communications

Patient Services: I authorize Supernus, and companies working with Supernus any of which may be branded as Circle of Care™ (collectively "Supernus"), to provide me with support services related to APOKYN, including: educational support provided in-person, online or by telephone, medication adherence services, as well as any information or materials related to such services. I authorize Supernus, and companies working with Supernus, to contact me to provide such services and information by mail, e-mail, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), and other mutually agreed upon means. I also authorize Supernus, and companies working with Supernus, to use my health information in connection with the services, including sharing such information with my healthcare provider, insurance provider, or pharmacy. I also authorize the disclosure of my health information to specific individuals that I have designated.

Other Communications: 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 to provide me with information about APOKYN services and programs. 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 understand that I may revoke this consent and choose not to receive services or information from Supernus by mailing a letter to the address set forth above in Section I of this Patient Authorization and Consent.

(OPTIONAL): I authorize the disclosure of my health information to the following designated individual(s) which are not a part of, endorsed by, or administered by the U.S. Department of Veterans Affairs:

NOTE HERE

_____ _____

Designated individual (print name) **Relationship**

E-mail _____

I have read, understand, and agree to the terms in section I above, Authorization to Share Health Information and section II above, Consent to Contact for Patient Services and Other Communications which are not a part of, endorsed by, or administered by the U.S. Department of Veterans Affairs, and I hereby authorize disclosures to the designated individual that I identified above (if applicable).

SIGN HERE

_____ _____

Signature of patient or legal representative **Date**

E-mail _____

Please fax pages 1 and 3 to 888-525-2431

NP.APO.2022-0023 04/22

HIPAA Authorization & Patient Services Consent for VA Patients – *Patient Copy*

Complete these forms if you are electing Circle of Care™ services

This document is a legal document and as such, consent must be given by the patient or the patient's legal representative. A patient should sign their own name. If the patient is unable to sign and the document is signed by a legal representative of the patient, the legal representative should sign their own name and attach proof of patient representation such as a Power of Attorney or other legal document.

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I have read, understand, and agree to the terms in section I above, Authorization to Share Health Information and section II above, Consent to Contact for Patient Services and Other Communications which are not a part of, endorsed by, or administered by the U.S. Department of Veterans Affairs, and I hereby authorize disclosures to the designated individual that I identified on page 1 (if applicable).

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

What is APOKYN?

APOKYN is a prescription medicine used to treat acute, intermittent "off" episodes (end-of-dose wearing "off" or unpredictable "on-off" episodes) in people with advanced Parkinson's disease (PD).

Who should not take APOKYN?

Do not take APOKYN if you are:

- taking certain medicines to treat nausea called 5HT$_3$ antagonists including Anzemet® (dolasetron), Kytril® (granisetron), Zofran® (ondansetron), Lotronex® (alosetron), and Aloxi® (palonosetron). People taking Zofran® (ondansetron) together with apomorphine, the active ingredient in APOKYN, have had very low blood pressure and lost consciousness or "blacked out"
- allergic to APOKYN or its ingredients and experience hives, itching, rash, or swelling (e.g., eyes, tongue, etc.). APOKYN also contains a sulfite called sodium metabisulfite. Sulfites can cause severe, life-threatening allergic reactions in some people, especially people with asthma.

What should I tell my healthcare provider before taking APOKYN?

Before you start using APOKYN, tell your healthcare provider if you:

- have difficulty staying awake during the daytime
- have dizziness, fainting spells or low blood pressure
- have asthma
- are allergic to any medicines containing sulfites
- have liver, kidney or heart problems
- have had a stroke or other brain problems
- have a mental problem called a major psychotic disorder
- drink alcohol
- are pregnant or plan to become pregnant, or if you are breastfeeding or plan to breastfeed. It is not known if APOKYN will harm your unborn baby or if APOKYN passes into your breast milk.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Using APOKYN with certain other medicines may affect each other and can cause serious side effects.

- If you take nitroglycerin under your tongue while using APOKYN, your blood pressure may decrease and cause dizziness. After taking nitroglycerin, lie down for at least 45 minutes.

What should I avoid while using APOKYN?

- **Do not** drink alcohol while using APOKYN. It can increase your chance of developing serious side effects.
- **Do not** take medicines that make you sleepy while you are using APOKYN.
- **Do not** drive, operate machinery, or do other dangerous activities until you know how APOKYN affects you.
- **Do not** change your body position too fast. Get up slowly from sitting or lying. APOKYN can lower your blood pressure and cause dizziness or fainting.

What are the possible side effects of APOKYN?

Tell your healthcare provider if you experience the following serious side effects:

- **blood clots.** Injecting APOKYN into a vein (intravenous) can cause blood clots. Do not inject APOKYN in your vein.
- **nausea and vomiting.** Severe nausea and vomiting can happen with APOKYN. Your healthcare provider may prescribe medicine called an antiemetic, such as trimethobenzamide (Tigan®), to help prevent it. If Tigan is prescribed, talk to your healthcare provider about how long you should remain on this medicine.
- **sleepiness or falling asleep during the day.** Some people treated with APOKYN may get sleepy during the day or fall asleep without warning while doing everyday activities such as talking, eating, or driving a car.
- **dizziness.** APOKYN can lower your blood pressure and cause dizziness. Dizziness can happen when APOKYN treatment is started or when the dose is increased. Do not get up too fast from sitting or lying down, especially if you have been sitting or lying down for a long period of time.
- **falls.** The changes that can happen with PD, and the effects of some PD medicines, can increase the risk of falling. APOKYN may also increase your risk of falling.
- **hallucinations or psychotic-like behavior.** APOKYN can cause or worsen psychotic-like behavior including hallucinations (seeing or hearing things that are not real), confusion, excessive suspicion, aggressive behavior, agitation, delusional beliefs (believing things that are not real), and disorganized thinking.
- **sudden uncontrolled movements (dyskinesias).** Some people with PD may get sudden, uncontrolled movements after treatment with some PD medicines. APOKYN can cause or make dyskinesias worse.
- **intense urges.** Some people with PD have reported new or increased gambling urges, increased sexual urges, and other intense urges, while taking PD medicines, including APOKYN.
- **heart problems.** If you have shortness of breath, fast heartbeat, or chest pain while taking APOKYN, call your healthcare provider or get emergency help right away.
- **serious heart rhythm changes (QT prolongation).** Tell your healthcare provider right away if you have a change in your heartbeat (a fast or irregular heartbeat), or if you faint.
- **injection site problems.** Bruising, swelling, and itching can happen at the injection site.
- **prolonged painful erections (priapism).** APOKYN may cause prolonged, painful erections in some people. If you have an erection that lasts more than 4 hours you should call your healthcare provider or go to the nearest hospital emergency room right away.

Other common side effects of APOKYN include:

- yawning
- runny nose
- confusion
- swelling of ankles/legs

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Patients and care partners must receive complete instructions on the proper use of APOKYN. Please see full Prescribing Information and Pen Instructions for Use/Patient Information.

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HIPAA Authorization & Patient Services Consent Form

Complete these forms if you are electing Circle of Care™ services

PATIENT INFORMATION

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

Daytime Phone: _____ Evening Phone: _____

E-mail: _____ Language Preference: ☐ English ☐ Spanish ☐ Other: _____

Care Partner/Alternate Contact:

Name: _____ Phone: _____

Relationship to Patient: _____ Best time to contact: ☐ Morning ☐ Afternoon

Prescribing Doctor Information

First Name: _____ Last Name: _____

VA Facility: _____

City: _____ State: _____ ZIP: _____ Phone: _____

PATIENT SERVICES CONSENT

By signing below, I request enrollment in the Circle of Care Clinical Education Program, whereby I elect to receive complementary Clinical Educator Support as selected, which are not a part of, endorsed by, or administered by the U.S. Department of Veterans Affairs:

The Circle of Care Program is optional and not required for APOKYN. You are not required to enroll. If you choose to enroll, select A or B below.

☐ A. Pre- and Post-Initiation Patient Support and Education: **If you select A, your APOKYN initiation will occur in your doctor's office.** Prior to the first administration of APOKYN by your doctor, the Circle of Care Clinical Educator will provide information about APOKYN and how to safely administer APOKYN via the injection device. Details include instructions on how to insert the cartridge and needle in the device and how to correctly operate the dial to ensure the proper dose. The Circle of Care Clinical Educator will make sure that you and your care partner are comfortable with the injection device and will also provide instructions about what to expect at the day of your initiation appointment when you receive your first APOKYN injection. If your doctor prescribes medication to be taken prior to your first APOKYN injection, the Clinical Educator will remind you of those instructions prior to your appointment. Pre-Initiation Education may be conducted in person or by telephone or video conference.

Circle of Care Clinical Educator services are available throughout your APOKYN therapy. The Circle of Care Clinical Educator will provide post initiation education and support to you and your care partner at a time that is convenient for you. Education may be provided in person, by telephone, or by video conference. In addition, as prescribed by your doctor, the Circle of Care Clinical Educator will teach and provide instructions on how to titrate your dose, if applicable and as needed, to ensure an effective and tolerated dose up to a maximum recommend dose of 0.6 mL.

☐ B. Initiation Support and Education: **By selecting option B, you will receive the pre- and post-initiation support and education as outlined above in option A, and your APOKYN initiation will occur in your home.** The Circle of Care Clinical Educator will schedule and coordinate your APOKYN initiation appointment to occur in your home. As prescribed by your doctor, the Circle of Care Clinical Educator will monitor your response to the starting test dose of APOKYN. In addition, as prescribed by your doctor, the Circle of Care Clinical Educator will teach and provide instructions on how to titrate your dose, if applicable and as needed, to ensure an effective and tolerated dose up to a maximum recommend dose of 0.6 mL.

If in-home initiation support and education by the Supernus Circle of Care Clinical Educator is requested by the patient, a copy of the APOKYN Prescription Form for VA Patients must be faxed to 888-525-2431.

SIGN HERE Signature: _____ Date: _____

Or

By signing below, I attest that I am the Patient's Caregiver and/or Power of Attorney signing on behalf of the Patient, and that I am currently 18 years of age or older.

Authorized representative signature: _____

Date: _____ Relationship to patient: _____

Please fax pages 1 and 3 to 888-525-2431

Please see the Important Safety Information and the accompanying full Prescribing Information and Pen Instructions for Use/Patient Information.

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