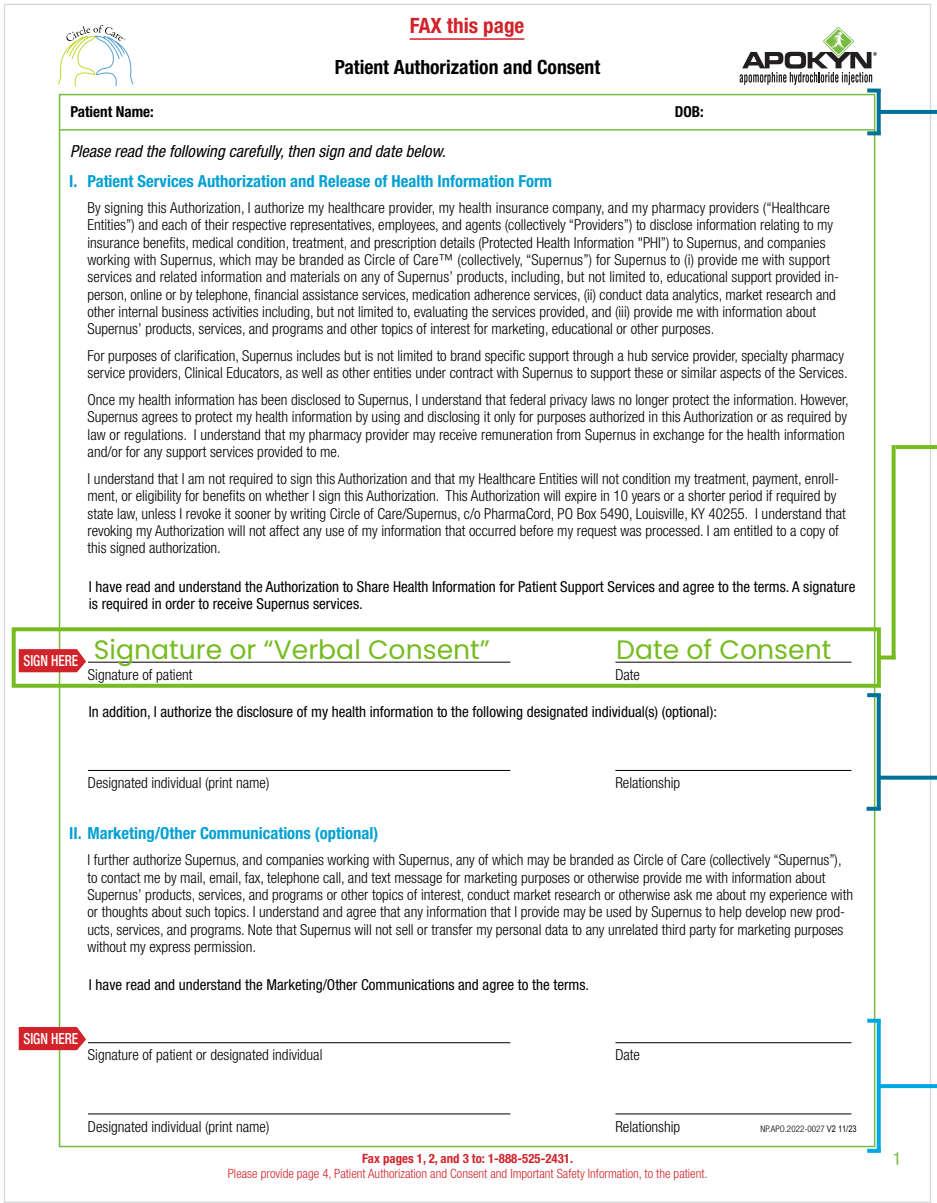
HOW TO FILL OUT THE PRESCRIPTION & ENROLLMENT FORM

Welcome to the APOKYN® Circle of Care™ Program. This guide will walk you through an example form to help ensure it's filled out completely and correctly.
Missing information may result in a delay in the process. Have questions? Please call 1-877-727-6596.

Fax completed **Patient Authorization and Consent Form** to Circle of Care at 1-888-525-2431 with a copy of the Prescription and Enrollment Form. Consent will be required for your patient to receive reimbursement support, clinical educational services, and product coordination.



FAX this page

Patient Authorization and Consent

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 or "Verbal Consent" — Signature of patient

Date of Consent — 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

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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.

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Clearly print patient name and DOB on the Patient Authorization and Consent Form.

★**IMPORTANT:** Have your patient read, complete, and sign Section I of Patient Authorization and Consent Form.

If patient is not in the office to sign, and verbal consent has been provided, please indicate by writing "Verbal Consent" and date of consent.

If patient has a designated care partner, their name and relationship can be added here.

To participate in further Circle of Care support services and continued communications, please ensure patient signs and provides designated care partner, if applicable.

Please retain a copy of the form for your own records. Additionally, please provide page 4 to your patient.

Circle of Care™

APOKYN® apomorphine hydrochloride injection

Missing information may result in a delay in patient enrollment. Have questions? Please call 1-877-727-6596.

Fax both pages of completed **Prescription and Enrollment Form** to Circle of Care at 1-888-525-2431 with a copy of the signed Patient Authorization and Consent Form. The APOKYN prescription must be signed, as this will be used by the Specialty Pharmacy to dispense your patient's medication.

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Prescription and Enrollment Form

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

APOKYN® apomorphine hydrochloride injection

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

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

OR

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.

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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.

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Please make sure patient indicates if it is OK to leave a message.

Attach copies of both sides of ALL insurance cards.

Check box for "no insurance" or "copay assistance" if eligible.

Confirm the diagnosis code.

★**IMPORTANT:** If your patient is new to APOKYN, ONLY complete the Initiation Rx section. **Check only 1 start dose. DO NOT select both.**

The Maintenance Rx section is **ONLY** completed for patients post-initiation. **DO NOT** fill out both Initiation and Maintenance sections.

★**IMPORTANT:** Sign DAW for APOKYN. Substitution to generic is generally permissible unless "DAW" is selected. **Please sign and date one line only.**

Please note state-specific requirements, and write "No Substitution" for applicable states.

Missing information may result in a delay in patient enrollment. Have questions? Please call 1-877-727-6596.

For New APOKYN Patients: Your patient will be automatically enrolled in the APOKYN Circle of Care Clinical Education Services as outlined below. Please select where the patient's initiation appointment will occur. If you prefer an alternative option for initiation and education, you can select that below.

Complete and sign the **Clinical Education Services** section of the Prescription and Enrollment Form. Fax to Circle of Care at 1-888-525-2431 with APOKYN prescription and copy of Patient Authorization and Consent Form.

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.

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Clearly print patient name and DOB on **EACH** page of Prescription and Enrollment Form.

NOTE: The Clinical Educator will provide education and ongoing support to your patient throughout their APOKYN treatment journey.

Specify APOKYN initiation location (office, home, or other).

Signature and date are **REQUIRED** for Clinical Education Services.

PLEASE PROVIDE PATIENT WITH A COPY OF THE AUTHORIZATION AND CONSENT FORM

Patient Authorization and Consent – Patient Copy

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.

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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.

This page should be provided to the patient.

Front

INDICATION

APOKYN is a prescription medicine used to treat acute, intermittent episodes of poor mobility called "off" episodes (end-of-dose wearing "off" or unpredictable "on-off" episodes) in people with advanced Parkinson's disease (PD). It is not known if APOKYN is safe and effective in children.

IMPORTANT SAFETY INFORMATION

Who should not take APOKYN?

Do not take APOKYN if you are:

- taking certain medicines to treat nausea called $5HT_3$ antagonists including ondansetron, granisetron, dolasetron, palonosetron, and alosetron. People taking 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?

Call your healthcare provider right away if you experience any of the following serious side effects:

- **allergic reaction**. An allergic reaction with side effects of hives, itching, rash, swelling (e.g., eyes, tongue, etc.); trouble breathing and/or swallowing may occur after injecting APOKYN.
- **blood clots**. Injecting APOKYN into a vein (intravenous) can cause blood clots. **Do not** inject APOKYN in your vein.
- **nausea and vomiting**. Nausea and vomiting, which may be severe, can happen with APOKYN. Your healthcare provider may prescribe a medicine to help decrease nausea and vomiting. Follow your healthcare provider's instructions on how to take and when to stop 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.
- **low red blood cells (hemolytic anemia)**. Tell your healthcare provider if you have any of the following signs or symptoms: you become pale, fast heartbeat, feel more tired or weaker than usual, skin or eyes look yellow, chest pain, shortness of breath or trouble breathing, dark-colored urine, fever, dizziness, or confusion.
- **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.
- **fever and confusion**. This can happen in some people when their PD medicine is stopped or there is a fast decrease in the dose of their PD medicine.
- **tissue changes (fibrotic complications)**. Some people have had changes in the tissues of their pelvis, lungs, and heart valves when taking medicines called nonergot derived dopamine agonists like APOKYN.
- **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.
- **swelling of ankles/legs**. APOKYN may cause swelling, especially in the ankles or legs. Tell your healthcare provider if you notice any swelling.

Other common side effects of APOKYN include:

- yawning • runny nose • confusion • swelling of your hands, arms, legs, and feet

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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