MedBox

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GOCOVRI REFERRAL FORM

Delivery Need By: Delivery to: ☐ Home Patients ☐ Office Physician's ☐ Other

1. Patient Information

Patient First Name ______ Patient Last Name ______ Date of Birth (MM/DD/YYYY) ______ Gender ☐ Male ☐ Female

Address ______ City ______ State ______ ZIP ______ US Resident ☐ Yes ☐ No

Email Address ______ Preferred Phone Number ______ Preferred Language ______

2. Insurance Information

Please attach a copy of both sides of the patient's insurance card(s) and/or fill out the insurance information to the right.

☐ Patient does not have insurance.

☐ Yes ☐ No Is the patient enrolled in a government funded healthcare program, such as Medicare, Medicaid, VA, DoD, or TRICARE?

Prescription Drug Plan Name ______

ID # ______ Group # ______ PCN # ______

BIN # ______ Phone Number ______

3. Clinical Information

Please confirm diagnosis: ☐ Dyskinesia in patients with Parkinson's disease receiving levodopa-based therapy OR ☐ Other ______

Allergies: ______

4. Prescriber Information

Prescriber Name ______ Prescriber NPI # ______ Prescriber State License # ______

Address ______ City ______ State ______ ZIP ______ Fax Number ______

Office Contact Name ______ Office Contact Email Address ______ Phone Number ______

5. Prescribing Instructions for GOCOVRI Capsules (Check box in both "Initial Rx" and "Maintenance Rx" sections)

Recommended Dosing

Initial Rx (New Patients)

☐ GOCOVRI 137 mg. Take 1 PO QHS x7 days; then 2 PO QHS. Dispense 53 caps. No refills.

Maintenance Rx

☐ GOCOVRI 137 mg. Take 2 PO QHS. Dispense 60 caps. Refills # ______

☐ Other ______

*Because elderly patients are more likely to have reduced renal function, care should be taken in dose selection.

Reduced Dosing for Patients With Moderate-to-Severe Renal Impairment*

Initial Rx (New Patients)

☐ GOCOVRI 68.5 mg. Take 1 PO QHS x7 days, then take 2 PO QHS x23 days. Dispense 53 caps. No refills.

☐ GOCOVRI 68.5 mg. Take 1 PO QHS x30 days. Dispense 30 caps. No refills.

Maintenance Rx

☐ GOCOVRI 137 mg. Take 1 PO QHS. Dispense 30 caps. Refills # ______

☐ GOCOVRI 68.5 mg. Take 1 PO QHS. Dispense 30 caps. Refills # ______

6. GOCOVRI Free Trial Program

I authorize the GOCOVRI Free Trial Program Pharmacy to dispense a free, one-time, 28-day supply of GOCOVRI. There is no purchase obligation to participate in the Free Trial Program. Terms and Conditions apply. This program is optional. See Free Trial Program Terms and Conditions on page 2.

Recommended Dosing

Initial Rx (New Patients)

☐ GOCOVRI 137 mg. Take 1 PO QHS x7 days; then 2 PO QHS. Dispense 49 caps. No refills.

☐ Other ______

*Because elderly patients are more likely to have reduced renal function, care should be taken in dose selection.

Reduced Dosing for Patients With Moderate-to-Severe Renal Impairment*

Initial Rx (New Patients)

○ GOCOVRI 68.5 mg. Take 1 PO QHS x7 days. Dispense 7 caps. No refills. GOCOVRI 137 mg. Take 1 PO QHS x21 days. Dispense 21 caps. No refills.

○ GOCOVRI 68.5 mg. Take 1 PO QHS x28 days. Dispense 28 caps. No refills.

7. Patient Signatures

☐ By checking this box, I agree to receive marketing information, offers and educational materials realated to my treatment.

______
Patient Signature for Authorization Date

8. Prescriber Certification

I certify that the information provided in this GOCOVRI™ (amantadine) extended release capsules Treatment Form is complete and accurate to the best of my knowledge. I have prescribed GOCOVRI based on my judgment of medical necessity, and I will supervise the patient's medical treatment. 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 Adamas Pharmaceuticals, Inc. for benefits eligibility, coverage authorization and coordination and dispensing of GOCOVRI, and providing me and my patient with other educational and support services associated with GOCOVRI. I authorize the forwarding of this prescription and the information to a dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program.

Prescriber's Signature (Sign either line A or B below.)

A. ______ Date ______ B. ______ Product Substitution Permitted Date ______

(Original signature required. If required by applicable law, please attach copies of all prescriptions on official state prescription forms.)

By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.