GOCOVRI®
(amantadine) extended release capsules

PRESCRIPTION FORM

Fax completed form to: **1-844-826-7626**.
For assistance, please call: **844-GOCOVRI (844-462-6874)**.

INCLUDING OPTIONAL 4-WEEK FREE TRIAL

1 PATIENT INFORMATION

Patient First Name | Patient Last Name

Date of Birth (MM/DD/YYYY)

Gender ☐ Male ☐ Female

US Resident ☐ Yes ☐ No

Address | City

State | Zip | Cellular Phone Number

Additional Phone Number | Email Address

Alternate Contact | Alternate Contact Phone Number

2 INSURANCE INFORMATION

Please attach a copy of both sides of the patient's insurance card(s).

☐ 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®?

3 CLINICAL INFORMATION

Please confirm diagnosis:

☐ **Dyskinesia** - Dyskinesia in patients with Parkinson's disease receiving levodopa-based therapy (**ICD-10: G20**)

☐ **OFF Episodes** - Adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing "off" episodes (**ICD-10: G20**)

☐ Other

Please list any allergies:

4 PATIENT SIGNATURES

I have read and agree to the Patient Authorization on page 2.

Patient Signature | **Date**

(Patient signature and date are required for services)

Initial here The signature above also denotes that I agree to receive marketing information, offers, and educational materials related to my treatment.

Initial here Initials denote I agree to Free Trial Program Terms and Conditions. No Patient Authorization on page 2 is required to receive a free trial.

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

5 PRESCRIBER INFORMATION

Prescriber Name

Prescriber NPI # | Prescriber State License #

Address: 1151 Old York Road, Suite 200 | City: Abington

State: PA | Zip: 19001 | Fax Number: 215-957-9254

Office Contact Name | Phone Number: 215-957-9250

Alternative Contact | Alternative Phone Number

6 GOCOVRI® 4-WEEK FREE TRIAL PROGRAM (OPTIONAL)

Not intended for patients who received a Free Sample

I authorize the GOCOVRI® Free Trial Program Pharmacy to dispense a free, one-time, 4-week 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.

Was patient previously provided a Free Sample of GOCOVRI®? ☐ Yes ☐ No

If a patient has received a sample of GOCOVRI®, they are not eligible for the Free Trial program.

☐ **GOCOVRI® 137 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (274 mg) PO QHS. Dispense 49 caps. No refills.

☐ **GOCOVRI® 68.5 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (137 mg) PO QHS. Dispense 49 caps. No refills.

☐ **GOCOVRI®** ____ **mg**. Take ____ cap(s) PO QHS x ____ days; then ____ cap(s) (____ mg) PO QHS. Dispense ____ caps. No refills.

Please proceed to box 7B (Maintenance Prescription) if Free Trial was completed

7 PRESCRIBING INSTRUCTIONS FOR GOCOVRI® CAPSULES

A INITIAL PRESCRIPTION for First Month

(For NEW patients who have NOT received Free Trial or Sample)

☐ **GOCOVRI® 137 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (274 mg) PO QHS. Dispense 53 caps. No refills.

☐ **GOCOVRI® 68.5 mg**. Take 1 cap PO QHS x 7 days; then 2 caps (137 mg) PO QHS. Dispense 53 caps. No refills.

☐ **GOCOVRI®** ____ **mg**. Take ____ cap(s) PO QHS x ____ days; then ____ cap(s) (____ mg) PO QHS. Dispense ____ caps. No refills.

B MAINTENANCE PRESCRIPTION for Continued Use

(For all patients)

☐ **GOCOVRI® 137 mg**. Take 2 caps (274 mg) PO QHS. Dispense 60 caps.

Number of refills ____

☐ **GOCOVRI®** ____ **mg**. Take ____ cap(s) (____ mg) PO QHS.

Dispense ____ caps. Number of refills ____

8 PRESCRIBER CERTIFICATION*

I certify that the information provided in this GOCOVRI® (amantadine) extended release capsules Prescription 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. (Adamas), and Adamas for benefits eligibility, coverage authorization, 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 Signature | **Date**

ADAMAS™

GOCOVRI ONBOARD® support focused on you

GOCOVRI®
(amantadine) extended release capsules

PRESCRIPTION FORM

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For assistance, please call: **844-GOCOVRI (844-462-6874)**.

INCLUDING OPTIONAL 4-WEEK FREE TRIAL

PRESCRIPTION FORM PATIENT AUTHORIZATION

I authorize my healthcare provider(s), pharmacy, and my health plan(s) to share my personal health information ("PHI"), including information about my medical condition, treatment, and health insurance benefits with Adamas and its service providers (collectively, "Adamas") in connection with Adamas' administration of the GOCOVRI Onboard® program (the "Program"). I understand that once Adamas receives my PHI, the information may be re-disclosed and no longer protected by federal privacy regulations.

I authorize Adamas to use my PHI, and to share my PHI with my healthcare provider(s) and insurance provider(s), in order to determine whether I am eligible for insurance coverage or other reimbursement for GOCOVRI® and to operate and assess the Program. I understand that the Program services may include communications with me, my healthcare providers, insurers, pharmacy, and specific individuals that are identified on the GOCOVRI Onboard® Prescription Form about treatment, compliance, and persistency, and I authorize Adamas to use my PHI, including the contact information I provided on the GOCOVRI Onboard® Prescription Form, to make those communications. I understand that I do not have to sign this Authorization in order to receive GOCOVRI®, as prescribed by my physician, or in order to receive any other healthcare, payment for healthcare, or to be eligible for healthcare benefits.

I understand that I may revoke this Authorization by notifying a Program representative by telephone (844-462-6874) or by sending a letter to GOCOVRI Onboard®, 130 Enterprise Drive, Pittsburgh, PA 15275. I understand that if I revoke this Authorization, that will not invalidate any uses or disclosures of my PHI made prior to the Program's receipt of my revocation and that I will no longer be able to receive GOCOVRI Onboard® services.

This Authorization expires on the specific date when I stop receiving services from GOCOVRI Onboard® unless otherwise required by law.

I have read this document or have had it explained to me. I understand that I am entitled to receive a copy of this Authorization once it has been signed.

FREE TRIAL PROGRAM TERMS AND CONDITIONS

The Free Trial Program provides eligible patients with a 28-day supply of GOCOVRI®. There is no purchase obligation to participate in the Free Trial Program. This Program is only for patients who are new to treatment and have an on-label prescription. Patients who elect to discontinue GOCOVRI® treatment after the Free Trial may be eligible to receive an additional 7-day supply of GOCOVRI® at a lower dose. Program offer expires December 31, 2021. Adamas reserves the right to modify or cancel this Program without notice at any time.

Patient: By signing on page 1, I certify that I will not seek reimbursement or credit for my Free Trial prescription from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I certify that I have never used GOCOVRI® before, including receiving a physical sample from my doctor.

Prescriber: By signing on page 1, I certify that this prescription is on label and the patient has not yet started GOCOVRI® treatment. I agree that I will not seek reimbursement from any government program or third-party insurer for any medication dispensed to the patient through the Free Trial Program. I certify that I have never prescribed or given GOCOVRI® to this patient before, including the provision of a physical sample from my office.

ADAMAS™

GOCOVRI ONBOARD® support focused on you

GET PATIENTS STARTED ON GOCOVRI® WITH THESE QUICK STEPS

GOCOVRI Onboard® partners with a Specialty Pharmacy to provide ONE direct line of contact and ensure timely fulfillment

YOU ARE HERE

1. Fill out, sign, and fax the Prescription Form to GOCOVRI Onboard® at 1-844-826-7626
   - Be sure to complete the Prescription Form before your patient leaves the office
2. A benefits verification is initiated
3. If a Prior Authorization (PA) is required, GOCOVRI Onboard® will initiate the PA and send to your office via CoverMyMeds
   - GOCOVRI Onboard® may reach out to you to ensure timely completion
4. The Specialty Pharmacy will call your patient to schedule next-day delivery of GOCOVRI®
   Note: your patients will need to speak with the Specialty Pharmacy over the phone in order to schedule their first delivery
   - If the Specialty Pharmacy is not able to reach the patient, they may reach out to you to help facilitate contact
5. The Specialty Pharmacy will follow up monthly to schedule recurring deliveries

YOUR DOCTOR IS STARTING YOU ON GOCOVRI®. HERE'S WHAT TO EXPECT:

STEP 1

Receiving GOCOVRI® starts with a call

In order to send your GOCOVRI®, our Specialty Pharmacy partner needs to speak to you over the phone. Expect a call from 1-412-413-8000, or call 1-844-GOCOVRI.

STEP 2

Your GOCOVRI® is EXPRESS mailed to you

Once you confirm your shipping address by phone, our Specialty Pharmacy partner will express deliver your medicine.

STEP 3

Expect a follow-up call

After you receive your GOCOVRI®, our Specialty Pharmacy partner will call again from the same number to answer any questions you may have and discuss next steps.

Scan this code to save the Specialty Pharmacy contact info to your phone

GOCOVRI® (amantadine) extended release capsules
68.5 mg | 137 mg