# Patient Enrollment Form

**Fax: 1-877-788-4943 | Phone: 1-855-4NUEDEX (1-855-468-3339)**
**Mail: PO Box 42886, Cincinnati, OH 45242**

NUEDEXTA®
(dextromethorphan HBr and quinidine sulfate) capsules 20 mg 10 mg

| Coverage Support | Patient Assistance Program | Additional Patient Resources |
|---|---|---|
| • Benefit verification/Prior authorization/Appeals assistance<br>• Co-pay assistance<br>**(complete sections I–section VI)** | • Free products for uninsured and underinsured patients<br>**(complete section I–section VII)** | • Convenient home delivery<br>• Helpful tools and educational resources<br>**(complete sections I–section VI)** |

## I. Patient Information

❑ **Patient contact information attached. If not, complete information below:**

First Name_____MI_____Last Name_____ Gender ❑M ❑F
Mailing Address_____City_____State_____ Zip_____
**Home Delivery? ❑Y ❑N Shipping Address_____City_____State_____Zip_____**
Home Phone (___)_____-_____Leave message? ❑Y ❑N Cell Phone (___)____-_____Leave message? ❑Y ❑N
Email_____Date of Birth_____SSN_____

Pharmacy Name and Location_____Phone (____)_____-_____

## II. Patient Insurance Information

❑ **Copy of prescription insurance card attached. If not, complete information below:**

Insurance Name_____
Insurance Phone Number_____
Policyholder's Name_____
Policyholder's Date of Birth_____

Member ID_____
RxGroup #_____
RxBIN #_____
RxPCN #_____

## III. Treatment Information/Prescription (to be completed by prescriber/physician only)

❑ **Copy of prescription attached. If not, complete information below:**

**NUEDEXTA®** (dextromethorphan HBr and quinidine sulfate) capsules | ICD-10: ❑ F48.2 ❑ Other_____ | # of Refills_____

Direction for Use:
❑ 1 capsule PO QD x 7 days, then 1 capsule PO Q12H
❑ 1 capsule PO Q12H

Concurrent Dx:
❑ Stroke
❑ Alzheimer's disease or other dementia
❑ Parkinson's disease
❑ Traumatic brain injury
❑ Multiple sclerosis
❑ Lou Gehrig's disease or Amyotropic lateral sclerosis (ALS)
❑ Other_____

Qty: ❑ 30-day supply with 7-day initial titration (53 caps) ❑ 30-day supply (60 caps) ❑ 90-day supply (180 caps)
❑ 60-day supply (120 caps) ❑ Other_____

❑ **Copy of treatment history/clinical notes attached. If not, please provide treatment history/clinical notes below:**

## IV. Prescriber Information

Prescriber Name_____Email_____Phone (215) 957 - 9250
Prescriber Type: ☑ Neurology ❑ Psychiatry ❑ Internal Medicine ❑ Geriatrician ❑ PA ❑ NP ❑ Other_____
NPI #_____TaxID #_____
Primary Office Contact_____Title/Role_____
Phone (215) 957 - 9250 Fax # (215) 957 - 9254 Email_____

## V. Prescriber/Physician Certification

I authorize AVANIR, on behalf of my patient, to forward to the pharmacy or insurer the diagnosis and/or clinical information, which I have provided, and/or any financial information, along with other pertinent information required by the insurer.

**Prescriber /Physician's Signature** _____ Date_____

## VI. Patient Authorization

By signing this Authorization, I authorize my healthcare provider, my health and prescription insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Avanir Pharmaceuticals, Inc, and its partners, including Triplefin LLC (collectively, "AVANIR"), health information relating to my medical condition, treatment and insurance coverage to provide me with support services (and related information and materials) related to AVANIR products, and conduct data analytics and other business activities related to such services. Once my health information has been disclosed to AVANIR, I understand that federal privacy laws no longer protect the information. However, AVANIR agrees to protect my health information by using and disclosing it only for purposes described in this Authorization or as required by law or regulations. Additionally, I authorize AVANIR to provide me with support services related to AVANIR products, including but not limited to: online support, financial assistance services, benefits verification, prior authorization, compliance and persistency and other therapy support services as well as any information or materials related to such services, AVANIR products and related disease states. I also authorize AVANIR to contact me to provide such services and information by mail, e-mail, fax, telephone call, text message and other mutually agreed upon means. I understand that standard text messaging rates may apply to any messages received. I also authorize AVANIR to use my health information in connection with the support services related to AVANIR products as part of the Advanced Patient Services, including, without limitation, sharing such information with Healthcare Entities. I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with AVANIR products), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive services and offerings related to Advanced Patient Services. I may cancel this Authorization at any time by mailing a letter to: PO Box 42886, Cincinnati, OH 45242. Canceling this Authorization will end my consent to further disclosure of my health information to AVANIR 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, my eligibility for health insurance or unsubscribe me from receiving information about AVANIR, its products or related disease state. This Authorization expires twenty (20) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I understand I have a right to have a copy of this form.

**I have read and understand the complete Authorization and agree to the terms.**

**Patient or Patient Representative's Signature** _____ Date_____

Patient Representative's Name (print)_____Relationship to Patient_____Date_____

Patient's Address_____

## VII. Financial Information (For PATIENT ASSISTANCE PROGRAM only)

❑ **Copy of gross annual household income attached. If not, complete information below:**

How many people live in your household? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ Other_____

Total annual household income (including salary/wages, social security income, disability income, any other income)*

❑ $0-$50,000 ❑ $50,000- $100,000 ❑ $100,000-$150,000 ❑ Greater than $150,000

*Supporting documentation may be required.