AVANIR® pharmaceuticals

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

ONZETRA™ Xsail™ (sumatriptan nasal powder) 11 mg per nosepiece

ADVANCED PATIENT SERVICES (APS) **Enrollment Form Instructions**

Healthcare Provider Instructions | To enroll your patient in APS, please follow these steps:

1. Have your patient (or patient representative) read the PATIENT CONSENT INFORMATION on the reverse side of this page. Request that the patient (or patient representative) complete the section in the ENROLLMENT FORM under "THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE PATIENT OR PATIENT REPRESENTATIVE". Then have the patient (or patient representative) sign the form in this section.

2. Complete the rest of the ENROLLMENT FORM under "THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE HEALTHCARE PROVIDER" and copy both sides of the patient's pharmacy benefit card(s), if available.

3. Once the ENROLLMENT FORM has been completely filled out by both you and your patient in your respective sections, send the form along with copies of the patient's pharmacy benefit card(s) (both front and back) via fax to 877-788-4943 or by mail to PO Box 42886 Cincinnati, OH 45242. Separately, please provide your patient with the PATIENT CONSENT INFORMATION pages. Your patient will soon be contacted by AVANIR. If you have any questions, please call 1-877-884-4003.

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ADVANCED PATIENT SERVICES (APS) **Patient Consent Information**

Patient Instructions | Please read the following. If you agree, sign and date the corresponding section of the ENROLLMENT FORM.

Authorization to Share Health Information and Participate in ADVANCED PATIENT SERVICES

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 companies working with AVANIR Pharmaceuticals, Inc. 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 NUEDEXTA and ONZETRA Xsail ("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 authorized 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 (the, "ADVANCED PATIENT SERVICES"). 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 also authorize AVANIR to use my health information in connection with the support services related to AVANIR Products and 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 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, or my eligibility for health insurance.

This Authorization expires five (5) 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.

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ADVANCED PATIENT SERVICES (APS) **Enrollment Form 1 of 2**

The following sections should be completed by the **Patient or the Patient's Representative**

Patient Information

Name_____Address_____

City_____State_____ Zip_____

Gender: ❑ Male ❑ Female Date of Birth_____

Email_____

Home Phone_____Cell Phone_____

Preferred Pharmacy Name_____Pharmacy Phone_____

❑ I would like to be contacted with more information about the Home Delivery Program

Prescription Drug Coverage & Insurance Information - *Please check the following that best describes the patient's coverage*

Insurance Type: ❑ Commercial ❑ Medicare Part D ❑ Medicaid ❑ No Insurance ❑ Other (Please indicate)_____

Patient has Secondary Insurance_____

Plan Name_____Policy Holder Name_____

Member #_____Group #_____RxBin #_____RxPCN #_____

Insurance Company Phone:_____Insurance Company Fax_____

Attach copies of both sides of patient's prescription drug benefit card used for pharmacy claims

Appropriate documentation required if requesting financial assistance

❑ Please contact me with information about financial support programs that I may be eligible for

**If requesting financial assistance please attach documentation of gross annual household income and complete the following:*

Number of People in Household_____Gross Annual Household Income_____

Authorization to Share Health Information and Participate in ADVANCED PATIENT SERVICES

I have read and understand the complete *Authorization to Share Health Information and Participate in ADVANCED PATIENT SERVICES* on the patient consent information sheet and agree to the terms.

Signature of Patient or Patient Representative_____Date_____

If signed by patient representative, please explain authority to act on behalf of the patient _____

(optional) I authorize the disclosure of my health information to the following designated individuals:

Designated Individual (Print name)_____Relationship_____

Please submit completed form by fax to 877-788-4943 or by mail to PO Box 42886, Cincinnati, OH 45242

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ADVANCED PATIENT SERVICES (APS) **Enrollment Form 2 of 2**

The following sections should be completed by the **Healthcare Provider**

AVANIR Product Support Requested

❑ **NUEDEXTA**® (dextromethorphan hydrobromide and quinidine sulfate)
30 day supply (60 per month)

❑ **ONZETRA**™ **Xsail**™ (sumatriptan nasal powder)
30 day supply (8 doses)

Prescriber Information

Name_____ Address 1151 Old York Road, Suite 200

City Abington State PA Zip 19001

NPI #_____ Specialty Neurology

Office Contact Name_____ Phone 215-957-9250

Fax 215-957-9254 Email_____

Diagnosis - *To be completed by physician only*

ICD-10 Code_____

Additional Clinical Information_____

Progress Notes - *Including brand and/or generic medications tried/failed and duration:*

Provide additional documentation if available.

Authorized Provider

I authorize AVANIR, on behalf of my patient, to forward to the pharmacy and/or insurer the diagnosis information, which I have provided, and/or any financial information, along with other pertinent information required by the insurer for the purpose of conducting a benefit verification and/or submitting a prior authorization on my behalf.

Prescriber Signature_____ Date_____

(Electronic signatures are acceptable)

Please submit completed form by fax to 877-788-4943 or by mail to PO Box 42886, Cincinnati, OH 45242