Osmolex ER™ (amantadine) Extended-release Tablets

Enrollment and Prescription Form

1-866-750-9516 1-833-OSMOLEX (1-833-676-6539)

ACCESS Osmolex™ SUPPORT CENTER

1 Patient Information

First Name _____ MI _____ Last Name _____

DOB (mm/dd/yyyy) _____ / _____ / _____ ☐ Male ☐ Female ☐ Long-Term Care Facility

Street Address _____

City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____

2 Patient Insurance Information

Please include a copy of the front and back of patient's prescription insurance card(s).

3 Healthcare Provider Information

HCP Name _____ ☐ MD ☐ DO ☐ PA ☐ NP

State License # _____ Physician NPI # _____

Office Name Abington Neurological Associates Phone (215) 957-9250 Fax (215) 957-9254

Street Address 1151 Old York Road, Suite 200

City Abington State PA Zip 19001

Office Contact Name _____

Office Contact Phone _____ Office Contact Email _____

4 Medical Information

Has the Patient Been Prescribed Amantadine IR? **Patient's Diagnosis Code** _____

☐ Yes Date of last use _____ ☐ No

Patient Received Samples ☐ Yes ☐ No **Sample Dose and Days Supply** _____

5 OSMOLEX ER Prescription Information

TITRATION DOSE* – 1st FILL
OSMOLEX ER (amantadine)

☐ 129 mg ☐ 193 mg ☐ 258 mg

Directions _____

_____

Quantity _____ Refills 0

*Use if intending to titrate

MAINTENANCE DOSE – 2nd FILL
OSMOLEX ER (amantadine)

☐ 129 mg ☐ 193 mg ☐ 258 mg ☐ 322 mg†

Directions _____

_____

Quantity _____ Refills _____

†322 mg dose dispensed as a 129 mg tablet + 193 mg tablet

6 Prescriber Signature

I certify that the above therapy is medically necessary and that the information provided is accurate, to the best of my knowledge. I certify that I am the prescriber who has prescribed OSMOLEX ER to the above-named patient and that I provided the patient with the full Prescribing Information for OSMOLEX ER. I authorize Vertical Pharmaceuticals, LLC and its affiliates, agents, representatives, and service providers to: (1) forward this prescription to a dispensing pharmacy that will dispense the medication to the above-named patient; (2) process this AccessOsmolex™ program application ("Application") and verify the information contained in this Application; and (3) administer, analyze, and improve the AccessOsmolex™ program, which includes comprehensive patient support services, such as benefits investigation and related coverage and reimbursement services to allow AccessOsmolex™ to help to ensure that the patient is able to appropriately access the drug that I have prescribed. I confirm that I have secured all necessary authorizations and consents so that I may share the patient's health information with Vertical Pharmaceuticals, LLC and its affiliates, agents, representatives, and service providers.

Prescriber Signature _____ Date _____

VERTICAL PHARMACEUTICALS, LLC