GOCOVRI™
(amantadine) extended release capsules

TREATMENT FORM

To enroll, please complete and fax this page to **1-844-826-7626.** For additional assistance, call **1-844-GOCOVRI (1-844-462-6874),** 8AM–8PM ET, M–F.

GOCOVRI™ ONBOARD
support focused on you

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 related to my treatment.

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

By signing below, I agree to the Free Trial Program Terms and Conditions on page 2.

_____ _____ _____ _____

Patient Signature for Authorization **Date** **Patient Signature for Free Trial** **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. _____ _____ **B.** _____ _____

Dispense as Written **Date** **Product Substitution Permitted** **Date**

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

ADAMAS™

Treatment Form Patient Authorization

I authorize Adamas Pharmaceuticals, Inc. ("Adamas") and its service providers, to use and disclose my protected health information ("PHI") to provide me with support services related to Adamas products. I understand these services may include, but are not limited to, online support, financial assistance, compliance and persistency and other treatment services, and information or materials related to such services. Services may also include (if I opt in to the use of my personal information to receive marketing information, offers and educational materials related to my treatment by checking the box in Section 7 on page 1 of this form) marketing materials, information on Adamas products, services, and other topics of interest, and contact by phone or email for market research or to ask about my experience with or thoughts on such topics. I understand that any person providing such services is not employed by my healthcare professional.

I authorize Adamas and its service providers to contact me to provide such services and information by mail, email, fax, telephone call, and text messages, using the contact information I provide on the GOCOVRI Onboard™ Treatment Form. I also authorize Adamas and its service providers to use my PHI in connection with the services, including, without limitation, sharing information with my healthcare provider(s), insurance provider, pharmacy, and specific individuals that are identified on the GOCOVRI Onboard Treatment Form.

I authorize my healthcare provider(s), pharmacy, and my health plan(s) to share information about me or my medical condition, including my PHI, with Adamas and its service providers, which may administer GOCOVRI Onboard. I authorize Adamas and its service providers to use and share this information to determine whether I am eligible for insurance coverage or other reimbursement for the medication(s) for which I am applying, whether I am eligible for GOCOVRI Onboard services, to administer GOCOVRI Onboard services, and to assess the quality of GOCOVRI Onboard services. I understand that once Adamas and its service providers receive my PHI, the information may be re-disclosed and no longer protected by federal privacy regulations.

I understand that pharmacies may receive payment from Adamas in connection with the use and disclosure of my PHI as described in this Authorization. I further authorize pharmacies to use my PHI to communicate with me about GOCOVRI and provide other services described in this Authorization and understand that they may receive a fee for such communications and services. I understand that I do not have to agree to receive these services and communications in order to receive GOCOVRI, as prescribed by my physician.

I certify that I am at least eighteen (18) years of age. I understand that my healthcare provider(s), pharmacy, and my health plan(s) may not condition current or future treatment, payment, or eligibility for benefits on whether I sign this Authorization. I understand that I may revoke my authorization and choose not to receive services or information from Adamas 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, the revocation will not apply to any information already used or disclosed pursuant to this Authorization 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 may request 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, 2019. 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.

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.