Supernus® Support Enrollment Form for Qelbree™

Fax completed form to Supernus® Support at 1-855-998-1515
Phone: 1-866-398-0833 • www.Qelbree.com

Supernus® Support

BENEFITS VERIFICATION

☐ Complete sections A, B, C, D & F.
Prescriber signature (D) and Patient Signature (F) required.

PATIENT ASSISTANCE PROGRAM

☐ Complete all sections.
All signatures required (D, E, F).

A PATIENT INFORMATION

NAME: (First, Middle, Last)	SUFFIX:	SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH:
ADDRESS:	CITY:	STATE:	ZIP:

PHONE:	MOBILE PHONE:	EMAIL:

PREFERRED COMMUNICATION: ☐ MOBILE ☐ PHONE ☐ TEXT ☐ EMAIL | BEST TIME TO CONTACT: ☐ AM ☐ PM

PERSON AUTHORIZED TO SPEAK ON YOUR BEHALF: | PATIENT PREFERRED LANGUAGE:

B PATIENT INSURANCE *Complete the information below or include copies of insurance cards

DOES PATIENT HAVE INSURANCE: ☐ YES ☐ NO	PATIENT PHARMACY:	DOES PATIENT HAVE PRESCRIPTION INSURANCE: ☐ YES ☐ NO

HEALTH PLAN INSURER?	RX PLAN:	MEMBER ID #:	RX MEMBER ID #:
PLAN PHONE #:	RX PLAN PHONE #:	CARDHOLDER NAME:	

CARDHOLDER DOB #: | RELATIONSHIP TO CARDHOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

C PRESCRIBER INFORMATION

PRESCRIBER NAME:	PRACTICE NAME:

MEDICAID ID#:	STATE LICENSE #:	SPECIALTY:

NPI #:	PRACTICE ADDRESS:	CITY:

STATE:	ZIP:	PHONE:	FAX:	OFFICE CONTACT NAME:

EMAIL: | PREFERRED COMMUNICATION: ☐ PHONE ☐ EMAIL ☐ FAX

D MEDICAL & PRESCRIPTION INFORMATION

☐ F90 ☐ F90.0 ☐ F90.1 ☐ F90.2 ☐ F90.8 ☐ F90.9 ☐ OTHER ☐ NO KNOWN DRUG ALLERGIES

ALLERGIES:

ADHD MEDICATIONS CURRENTLY TAKING:	CONCURRENT MEDICATIONS:

ADHD MEDICATIONS PREVIOUSLY TRIED AND FAILED WITH REASON FOR DISCONTINUATION:

1. MEDICATION: REASON: DATE OF DISCONTINUATION:

2. MEDICATION: REASON: DATE OF DISCONTINUATION:

WEIGHT:	HEIGHT:	BMI:

Qelbree: ☐ 100 MG ☐ 150 MG ☐ 200 MG | QUANTITY: | REFILLS:

DIRECTIONS:

I certify that this therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the physician that has prescribed Qelbree to the previously identified patient. I authorize PharmaCord® on behalf of my patient to facilitate processes to assist the patient in obtaining Qelbree as indicated on this prescription.

SIGN HERE

PRESCRIBER SIGNATURE:	DATE:

ORIGINAL SIGNATURE OF PRESCRIBER ☐ **DISPENSE AS WRITTEN** **INVALID WITHOUT DATE**

Please fax to 1-855-998-1515

E PATIENT ASSISTANCE PROGRAM ELIGIBILITY

NAME (FIRST, MIDDLE, LAST): DOB:

IS PATIENT LEGAL US RESIDENT: ☐ YES ☐ NO HOUSEHOLD SIZE BASED ON IRS FORM 1040 OR 1040 EZ:

ADJUSTED GROSS INCOME AS IT APPEARS ON THE MOST RECENT YEAR'S FEDERAL TAX RETURN: $ YEAR:

HAVE YOU APPLIED FOR MEDICAID OR OTHER STATUTE-FUNDED PROGRAM(S)?: ☐ YES ☐ NO

IF NOT APPROVED FOR OTHER PROGRAMS, REASONS FOR DENIAL:

I understand that I am providing written instructions authorizing Supernus Pharmaceuticals and its vendor, under the Fair Credit Reporting Act ("FRCA"), to obtain information from my credit profile or other information from Experian Health, for the purpose of determining financial qualifications for programs administered by Supernus Pharmaceuticals. I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I understand that completing this application form is not a guarantee of eligibility for the SupernusSupport Patient Assistance Program. I also understand that Supernus Pharmaceuticals may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare Part D plan, I cannot utilize my Part D plan benefits for products received through the SupernusSupport Patient Assistance Program for the duration of my enrollment. Any medication I receive through the SupernusSupport Patient Assistance Program will not count toward my true out-of-pocket (TrOOP) expenses in Medicare Part D.

SIGN HERE

PATIENT SIGNATURE: DATE: RELATIONSHIP TO PATIENT
☐ SELF ☐ SPOUSE ☐ CHILD

F READ AND SIGN PATIENT AUTHORIZATION

I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Supernus Pharmaceuticals and companies working with Supernus Pharmaceuticals, which may be branded as Supernus® Support (collectively, "Supernus Pharmaceuticals"), my contact information, health information relating to my medical condition to the extent necessary to support treatment that may also include identifying any potential drug interactions, evaluation, and allergies, and insurance coverage for Supernus Pharmaceuticals to (i) provide me with support services (which may be branded as Supernus® Support) and related information and materials on any of Supernus Pharmaceuticals' products, including, but not limited to, educational support provided in-person, online, or by telephone, financial assistance services, and medication adherence services; (ii) conduct data analytics, market research, and other internal business activities including, but not limited to, evaluating the services provided; and (iii) provide me with information about Supernus Pharmaceuticals' products, services, and programs and other topics of interest for marketing, educational, or other purposes. Once my health information has been disclosed to Supernus Pharmaceuticals, I understand that federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Supernus Pharmaceuticals. However, Supernus Pharmaceuticals agrees to protect my health information by using and disclosing it only for purposes authorized in this Patient Authorization and Consent or as required by law or regulations. I understand that I may refuse to sign this Authorization, and I further understand that my treatment (including with a Supernus Pharmaceuticals product), payment for treatment, insurance enrollment, or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign this Authorization, or later cancel it, I will not be able to receive any support services from Supernus Pharmaceuticals, including those branded as Supernus® Support. I may cancel this Authorization at any time by emailing a letter to: SupernusSupport@PharmaCord.com. Canceling this Authorization will end my consent to further disclose health information to Supernus Pharmaceuticals 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 December 31, 2028 or such shorter time frame 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 have read, understand, and agree to the terms in this section, Authorization to Share Health Information.

SIGN HERE

PATIENT SIGNATURE: DATE: RELATIONSHIP TO PATIENT
☐ SELF ☐ SPOUSE ☐ CHILD