RYZUP™ SUPPORT SERVICES

Lumryz™ (sodium oxybate) for extended-release oral suspension CIII

Patient Assistance Program (PAP)

Complete all RYZUP Support Services enrollment forms online at RYZUPSupport.com, or complete and fax to **1-844-485-7638**.

Have questions on completing enrollment?
Please call **1-844-485-7636** Monday to Friday 8 AM - 8 PM ET.

Please fill out the form on the next page.

Scan to complete online.

Patient Assistance Program Eligibility Criteria

- ✓ Patient and HCP must be enrolled in the LUMRYZ REMS. Go to LUMRYZREMS.com to enroll
- ✓ Patient must have no prescription drug coverage for LUMRYZ
- ✓ Patient must be diagnosed and prescribed LUMRYZ for FDA-approved use per label
- ✓ Patient must reside in the United States
- ✓ Patient must meet program financial requirements
- ✓ Patient must agree to an electronic income verification (soft credit check) OR
  - Provide proof of income (tax return, pay stubs, bank statements, social security award letter, unemployment check, etc)
  - Provide receipts for required medical expenses
  - Provide required documentation on out-of-pocket expenditures (applies to Medicare only)

Please see the full Prescribing Information, including BOXED WARNING, and Medication Guide, available on LUMRYZ.com.

Patient Assistance Program

*Required field.

Patient Information (to be filled out by patient or guardian and signed in section below)

*First Name:	M.I.:	*Last Name:	*Phone:
*Date of Birth (MM/DD/YYYY):	*Gender: ☐ Male ☐ Female ☐ Other		Cell Phone:
*Address Line 1:			Email:
Address Line 2:	Preferred Method of Contact: ☐ Phone ☐ Cell ☐ Email ☐ OK to leave message		
*City:		*State:	*Zip Code:
*Are you a US citizen or resident? ☐ Yes ☐ No		*What is your total annual household income? $	
*Do you have private prescription insurance coverage? ☐ Yes ☐ No		*How many people live in your household (including yourself)?	
*Are you enrolled in Medicare Part A and/or Part B? ☐ Yes ☐ No		*Have you enrolled in Medicaid? ☐ Yes ☐ No	

PATIENT: FORM MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED

By signing below, I acknowledge that:

- I certify that I do not have insurance coverage for LUMRYZ (sodium oxybate) for extended-release oral suspension and that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program.
- I understand that If I am eligible or enrolled in a Medicare plan, I will (i) not seek the requested medication from my Medicare plan for the remainder of the enrollment calendar year; (ii) not seek true out-of-pocket (TrOOP) credit for any medication received from the RYZUP PAP; and (iii) agree to notify my Medicare plan that I will receive LUMRYZ for free through the RYZUP PAP until the end of the enrollment calendar year.
- I agree to an electronic income verification and understand that the RYZUP PAP may ask for proof of income at any time for the purpose of audit/verification. (This is a soft inquiry and will not affect your credit score.) If requested, I agree to provide proof of income within thirty (30) days of the request.
- I agree to notify the RYZUP PAP if there are changes to my prescription, income, or insurance coverage, and I understand that such a change could impact my eligibility for the RYZUP PAP. I understand that the RYZUP PAP will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed to me.
- I authorize the RYZUP PAP and its affiliates to forward information in this RYZUP PAP Enrollment Form to a dispensing pharmacy on my behalf.
- I understand that completing this application does not ensure that I will qualify for the RYZUP PAP and that Avadel CNS Pharmaceuticals, LLC reserves the right to modify the application form, modify or discontinue the program, or terminate assistance at any time and without notice. If I do qualify for free medicine, I understand it will be through the end of the enrollment calendar year, and should I require assistance in future years, I must reapply for the RYZUP PAP.
- To qualify for the RYZUP PAP, I understand that I must meet the program eligibility criteria, and I certify that I have read and agree to the above PAP patient acknowledgment and that all information in this application, including information about household income, is complete and accurate.

_____ _____

*Patient/Guardian Signature *Date

_____ _____

*Printed Patient/Guardian Name Relationship, if applicable

PRESCRIBER: FORM MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED

By signing below, I acknowledge that:

- To the best of my knowledge, this patient has no coverage (including Medicare, Medicaid, or other federal healthcare programs) for LUMRYZ.
- I certify that LUMRYZ is medically necessary and prescribed for an FDA-approved use for this patient and that I have reviewed this therapy. Additionally, I confirm that I have reviewed both the Important Safety Information (ISI) and the Prescribing Information (PI) with the patient and will be monitoring the patient's treatment.

_____ _____

*Prescriber Signature *Date

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*Printed Prescriber Name (First and Last)

Please see the full Prescribing Information, including BOXED WARNING, and Medication Guide, available on LUMRYZ.com.