RYZUP™ SUPPORT SERVICES

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

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.

Enrollment Checklist

NOTE: TO RECEIVE LUMRYZ, PATIENTS AND THEIR PRESCRIBERS MUST BE ENROLLED IN THE LUMRYZ REMS. GO TO LUMRYZREMS.com TO ENROLL.

Please complete the appropriate forms to enroll your patient into RYZUP Support Services.

RYZUP Support Services

- ☐ For HCPs, please complete the RYZUP Support Services Enrollment Form
- ☐ Have patient complete the RYZUP Support Services Authorization Form

Scan to complete online.

- ☐ Have patient and HCP complete the RYZUP Support Services Patient Assistance Program Application (if applicable)

Specialty Pharmacy

- ☐ For HCPs, please complete and fax the LUMRYZ Prescription Form to the specialty pharmacy

  (Note: This form may not satisfy all legal requirements for prescribing LUMRYZ in your state. Please submit all prescriptions in accordance with applicable state laws or as required by institutional policy.)

Scan to print form.

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

Enrollment Form

NOTE: TO RECEIVE LUMRYZ (SODIUM OXYBATE) FOR EXTENDED-RELEASE ORAL SUSPENSION, PATIENTS AND THEIR PRESCRIBERS MUST BE ENROLLED IN THE LUMRYZ REMS. GO TO LUMRYZREMS.com TO ENROLL.

*Required field. All sections to be filled out and signed by healthcare provider.

Patient Information

*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:

Insurance Information (please include copies of the front and back of the insurance card)

Does the patient have insurance? ☐ Yes ☐ No	Does the patient have secondary insurance? ☐ Yes ☐ No	
Policy Holder's Name:	Relationship to Patient:	
Insurance Company Name:	Policy Holder's Date of Birth (MM/DD/YYYY):	
Insurance Phone:	Rx Member ID No:	Rx Group No:

Prescriber Information

*First Name:	M.I.:	*Last Name:	*Primary Phone:
*Street Address:			Practice/Facility Name:
*City:	*State:	*Zip Code:	*Fax:
*NPI No:	*DEA No:		State License No:
Office Contact Name:	Office Contact Phone:		
Office Contact Email:	Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax		

LUMRYZ Prescription and Clinical Information

(This information is for benefits investigation purposes only. This form does not constitute a valid prescription.)

*Diagnosis (ICD-10 code):

- ☐ G47.41
- ☐ G47.42
- ☐ G47.411
- ☐ G47.421

Please select patient's experience with oxybate products:

- ☐ Naïve to oxybate
- ☐ Discontinued oxybate
- ☐ Currently taking oxybate

If **switching** from another oxybate product, please select closest total nightly dosage:

- ☐ LUMRYZ 4.5 g
- ☐ LUMRYZ 6 g
- ☐ LUMRYZ 7.5 g
- ☐ LUMRYZ 9 g

OR

If **not** currently taking oxybate products, please select ONE titration schedule:

- ☐ Pivotal clinical trial schedule:
  - Week 1: 4.5 g
  - Week 2 and 3: 6 g
  - Week 4: 7.5 g
- ☐ Other titration schedule
  - Week 1: ___ g
  - Week 2: ___ g
  - Week 3: ___ g
  - Week 4: ___ g

Prescriber Attestation and Consent

(Form must be signed by healthcare provider before enrollment can be processed.)

By signing below, I certify that the patient and physician information contained in this RYZUP Support Services Enrollment Form is complete and accurate to the best of my knowledge. I certify that LUMRYZ (sodium oxybate) for extended-release oral suspension is medically necessary 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. I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to RYZUP Support Services for the purposes of verifying the patient's insurance coverage, seeking prior authorization on my patient's behalf, if needed, and providing information on appeals for denials of claims. I understand that my patient's information provided to Avadel CNS Pharmaceuticals, LLC and their affiliates and agents (together, "Avadel") is for the use of RYZUP Support Services solely to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for patient assistance and other support programs; and to otherwise administer RYZUP Support Services for my patient. I authorize the use of said patient affordability programs where applicable. I consent to RYZUP Support Services contacting me by fax, email, phone, or mail to provide additional information about LUMRYZ and RYZUP Support Services.

_____ *Prescriber Signature

_____ *Date

Please note that the pharmacies certified in the LUMRYZ REMS to dispense LUMRYZ are Accredo®, CVS Specialty™, Frontier Therapies - Optum, and ARx Patient Solutions Pharmacy.

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