RYZUP Patient Enrollment Form

RYZUP SUPPORT SERVICES | Lumryz™ (sodium oxybate) for extended-release oral suspension ℂ

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.

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.

*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 primary insurance card)

Does the patient have insurance? ☐ Yes ☐ No	Does the patient have secondary insurance? ☐ Yes ☐ No	
Policy Holder's Name:	Relationship to Patient:	
Primary Rx Insurance 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 Fax:
Office Contact Email:	Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax		

LUMRYZ Clinical Information For Benefits Investigation (This form does not constitute a valid prescription.)

*Diagnosis (ICD-10 code):
- ☐ G47.411 - Narcolepsy with cataplexy
- ☐ G47.419 - Narcolepsy without cataplexy
- ☐ Other: _____

Please select patient's experience with oxybate products:
- ☐ Naïve to oxybate
- ☐ Discontinued oxybate
- ☐ Currently taking oxybate

If switching from another oxybate product, please select nearest equivalent 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

OR

☐ 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 or authorized agent 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 or others in my healthcare provider practice group ("my Practice") have obtained written authorization from the patient named in this Enrollment Form that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 and/or state law, and authorizes me and my Practice, to disclose the patient's personal health information (PHI) and the information disclosed in this Enrollment Form to Avadel CNS Pharmaceuticals, LLC and its affiliates and agents, including RYZUP Support Services and Avadel's field reimbursement team (together, "Avadel"), and authorizes Avadel to use and disclose the PHI for the purposes of benefits investigation to verify my patient's insurance coverage; reimbursement support; to assess, if applicable, my patient's eligibility for patient assistance and other affordability programs; and to otherwise administer RYZUP Support Services for my patient. I consent to Avadel contacting me by fax, email, phone, or mail to communicate information about LUMRYZ and my patient's participation in RYZUP Support Services.

_____ *Prescriber or Authorized Agent Signature

_____ *Date

Please see full Prescribing Information, including BOXED Warning, and Medication Guide.

Avadel™

Phone: 1-844-485-7636 | RYZUPSupport.com | Fax: 1-844-485-7638