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.

Patient Assistance Program (PAP) Application

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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.

Avadel CNS Pharmaceuticals, LLC provides medically necessary LUMRYZ free of charge to qualifying applicants through its Patient Assistance Program ("PAP" or "Program"). The Program is administered by Avadel CNS Pharmaceuticals, LLC (d/b/a RYZUP Support Services) and its affiliates, agents and representatives, including its third-party patient support program service provider (hereinafter collectively, "Avadel"). Submission of a complete application does not guarantee enrollment into the Program. Each application will be considered on a case-by-case basis.

Patient Assistance Program Eligibility Criteria

- ✓ Patient and HCP must be enrolled in the LUMRYZ REMS. Go to LUMRYZREMS.com to enroll
- ✓ Patient must be uninsured or underinsured for LUMRYZ
- ✓ Patient must be diagnosed and prescribed LUMRYZ for FDA-approved use per label
- ✓ Patient must reside in the United States or Puerto Rico
- ✓ 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 Part D only)

*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 D? ☐ Yes ☐ No Member ID#	*Have you enrolled in Medicaid? ☐ Yes ☐ No

PAP Application Cont.

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PATIENT DECLARATION

I understand that completing this application does not ensure that I will qualify for this Program and that any assistance in the form of free medicine is contingent on my ability to meet the Program eligibility criteria as determined by Avadel. 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 Program. There is no guarantee that assistance will be available in any subsequent year(s).

I certify that I do not have insurance coverage for LUMRYZ (sodium oxybate) for extended-release oral suspension and that I will not seek or accept reimbursement or credit for this prescription from any insurer, health plan, or government program. I agree to notify the Program within thirty (30) days if there are changes to my prescription, income, or insurance coverage, and I understand that such a change could impact my eligibility for the Program. I understand that Program assistance will terminate if the Program becomes aware of any fraud or if this medication is no longer prescribed to me.

I authorize Avadel to forward information in this application to a dispensing pharmacy on my behalf.

I agree that Avadel shall not be liable for any damages of any kind, without limitation, in connection with my receiving assistance, benefits or services provided by the Program. Avadel reserves the right to modify the application form, modify or discontinue the Program, or terminate assistance at any time for any reason and without notice.

I certify that I have read and agree to the above Patient Declaration 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

FAIR CREDIT REPORTING ACT (FCRA) CONSENT

I authorize Avadel under the Fair Credit Reporting Act ("FCRA") to obtain information from my credit profile or other information through electronic income verification which will include a soft credit check solely for the purpose of determining my financial eligibility for PAP. (This is a soft inquiry and will not affect your credit score.) I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I understand that, if requested by Avadel, I may need to provide additional proof of income within thirty (30) days of the request.

_____ _____

*Patient/Guardian Signature | *Date

_____ _____

*Printed Patient/Guardian Name | Relationship, if applicable

PAP Application Cont.

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PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize my healthcare providers and staff, pharmacies, health insurer(s), health plans or programs that provide me health benefits to disclose any and all necessary information, including but not limited to, my Protected Health Information (PHI) (collectively, "Personal Information") included on this application as well as information related to my medical condition, treatment, care management, health insurance coverage and claims, and prescription medications to Avadel for the purposes described below.

I understand that the purpose of this Authorization is to aid Avadel in administering the PAP by: (i) processing my application; (ii) verifying my information; (iii) assessing my eligibility for PAP and other patient assistance resources; (iv) coordinating prescription fulfillment; (v) conducting additional services to run the PAP; (vi) conducting quality assurance and/or other internal business activities in connection with PAP; and (vii) contacting me via mail, email, text message, phone or fax for PAP-related purposes, including as part of PAP audits and to request additional information from me.

I understand that once my Personal Information is disclosed pursuant to this Authorization, it may no longer be protected by federal privacy and security laws or applicable state laws and could be re-disclosed to others, but I also understand that the Program intends to use and disclose my Personal Information only for the purposes stated herein. I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits, but if I do not sign this Authorization, I will not be able to obtain assistance from the Program. I further understand that I may cancel this Authorization at any time in the future by calling RYZUP Support Services at 1-844-485-7636 or by mailing a written request for cancellation to RYZUP Support Services, P.O. Box 7613, Overland Park, KS 66207. If I cancel this Authorization, Avadel will stop using or sharing my Personal Information (except as necessary to end participation) but such cancellation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this Authorization. If I do not cancel it, this Authorization will remain in effect until I am no longer participating in the Program or until the Authorization is required to be terminated (i.e., if a shorter time frame is required by applicable law). I understand that I am entitled to receive a copy of this Authorization. By signing below, I acknowledge that I have read and agree to the Patient Authorization above.

*Patient/Guardian Signature	*Date
*Printed Patient/Guardian Name	Relationship, if applicable

PATIENT MEDICARE PART D ENROLLEE CONSENT - TO BE COMPLETED BY PATIENT (IF APPLICABLE)

I agree that if I am approved for PAP assistance as a Medicare Part D enrollee, Avadel may give my Personal Information to the Centers for Medicare & Medicaid Services ("CMS") to confirm my Medicare Part D enrollment status and let CMS and my Medicare Part D plan know of my enrollment in PAP. I understand that if approved for assistance, I will be able to receive the PAP medicine from the Program for the remainder of the calendar year for which my application was approved. I agree that I: (i) will not seek the PAP medicine from my Medicare Part D prescription plan while receiving the PAP medicine from the Program; (ii) will not seek or accept reimbursement for any PAP medicine dispensed by the Program from any government program or third-party insurer; (iii) will not seek credit for any PAP medicine toward my True-Out-of-Pocket ("TrOOP") costs because I understand that PAP medicine received from the Program will not count toward my TrOOP; and (iv) will notify the Program within thirty (30) days if my prescription drug coverage changes in any way.

Signature required ONLY if patient is a Medicare Part D enrollee:

*Patient/Guardian Signature	*Date
*Printed Patient/Guardian Name	Relationship, if applicable

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