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:	Policy Holder's Date of Birth (mm/dd/yyyy):
Primary Rx Insurance Name:	Rx Member ID No:	Rx Group No:
Insurance Phone:	Rx Bin:	Rx PCN:

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

Current nightly dose: _____

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:

- ☐ LUMRYZ Starter Pack:
  - 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

Patient Authorization Form

RYZUP SUPPORT SERVICES

*Required field. All sections to be filled out and signed by patient or guardian.

Patient Information		
*First Name:	*Last Name:	Email:
*Date of Birth (MM/DD/YYYY):	*Phone:	Cell Phone:

Patient Authorization to Use and Disclose Protected Health Information ("Authorization")

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 the RYZUP Support Services Patient Enrollment Form as well as information related to my medical condition and treatment, health insurance coverage and claims, and prescription medications, to 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") to provide me with access to services related to my prescribed medication and/or medical condition (the "Program"). I understand that my pharmacy providers may receive remuneration for using or disclosing my protected health information pursuant to this authorization.

Specifically, I authorize Avadel to receive, use, and disclose my Personal Information to (i) enroll me in the Program; (ii) conduct benefits investigation(s) and coordinate my insurance coverage, which may include allowing an Avadel field based representative to access my Personal Information and engage with my healthcare providers and health insurer(s) directly, if necessary; (iii) if needed, determine my eligibility for and coordinate financial assistance; (iv) coordinate prescription fulfillment and product replacement; (v) facilitate quality and adverse event reporting activities; (vi) conduct data analytics and Program-related business activities; (vii) provide Program educational materials and information; (viii) contact me by mail, telephone or email or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders and support, for which my pharmacy providers may receive financial remuneration from Avadel.

I understand that any Personal Information disclosed pursuant to this Authorization, once disclosed, will no longer be protected by federal privacy and security laws or applicable state laws. I understand that if I choose not to provide this Authorization, I will not be able to participate in the Program, but I will still be eligible for healthcare treatment and insurance benefits. I understand I may cancel this Authorization at any time 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. I understand that canceling my Authorization means my healthcare provider, pharmacies, and health plans, as well as Avadel, may no longer rely on the Authorization to use or disclose my Personal Information, but it will not affect previous disclosures by them pursuant to 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 (First and Last) Relationship, if applicable

☐ **Marketing Communications Opt-in (Optional):** By checking this box, I certify that I am at least 18 years old and consent to receive marketing, educational and informational communications from Avadel, its affiliates and agents by direct mail, email and to the phone number I provided, including text messages, prerecorded messages and phone calls, which may be sent via autodialer, to provide me with information about Avadel products, services, and programs or other topics of interest, including to conduct market research. I understand my consent is not a condition of purchase of my prescribed medication. Text and data rates may apply. I may opt out at any time by texting "STOP". Additional terms apply: https://www.avadel.com/terms-and-conditions.