RYZUP Patient 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 <u>LUMRYZREMS.com</u> TO ENROLL.

Complete all RYZUP Support Services enrollment forms online at RYZUPSupport.com, or complete and fax to **1-877-206-3198**. 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:		Poli	olicy Holder's Date of Birth (mm/dd/yyyy):		
Primary Rx Insurance Name:		Rx Member ID No:		Rx (x Group No:		
Insurance Phone:		Rx Bin: Rx		Rx I	PCN:		
Prescriber Information							
*First Name:		M.I.:	*Last Name:		*Primary Phone:		
*Street Address:		l .			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			ail 🗌 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: Currently taking ox Current nightly do:		pate xybate	If switching from another oxyba product, please select nearest equivalent total nightly dosage: LUMRYZ 4.5 g LUMRYZ 6 g LUMRYZ 7.5 g LUMRYZ 9 g	-	If not currently taking oxybate products, please select ONE titration schedule: LUMRYZ OR Other titration schedule Starter Pack: Week 1:g Week 1:g Week 2 and 3: 6 g Week 4: 7.5 g Week 4: 7.5 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 $\underline{\text{Prescribing Information}}$, including BOXED Warning, and $\underline{\text{Medication Guide.}}$





Patient Authorization Form



Required field. All sections to be filled out and signed b	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 Protec	ted Health Information ("Authorization")	
I authorize my healthcare providers and staff, pharmany and all necessary information, including but no on the RYZUP Support Services Patient Enrollment coverage and claims, and prescription medications, representatives, including its third-party patient supservices related to my prescribed medication and/oremuneration for using or disclosing my protected. Specifically, I authorize Avadel to receive, use, and cinvestigation(s) and coordinate my insurance coveral information and engage with my healthcare provide coordinate financial assistance; (iv) coordinate presactivities; (vi) conduct data analytics and Programme by mail, telephone, text or email or to any future Program services, including adherence related commenuneration from Avadel. I understand that any Personal Information disclose and security laws or applicable state laws. I understand security laws or applicable for healthcare tree RYZUP Support Services at 1-844-485-7636 or by m KS 66207. I understand that canceling my Authorizationger rely on the Authorization to use or disclose a Authorization. If I do not cancel it, this Authorization required to be terminated (i.e., if a shorter time fram Authorization. By signing below, I acknowledge that	It limited to my Protected Health Information (PHForm as well as information related to my medicate to Avadel CNS Pharmaceuticals, LLC (d/b/a RYZ) port program service provider (hereinafter collecter medical condition (the "Program"). I understand health information pursuant to this authorization disclose my Personal Information to (i) enroll meage, which may include allowing an Avadel field lears and health insurer(s) directly, if necessary; (iii) cription fulfillment and product replacement; (v) elated business activities; (vii) provide Program elected to the contact information provided by me or on my be accontact information provided by me or on my be accontact information provided this Authorization and that if I choose not to provide this Authorization and that if I choose not to provide this Authorization and insurance benefits. I understand I manailing a written request for cancellation to RYZU ation means my healthcare provider, pharmacies, my Personal Information, but it will not affect premium will remain in effect until I am no longer participes is required by applicable law). I understand that	I) (collectively, "Personal Information") included al condition and treatment, health insurance UP Support Services) and its affiliates, agents and ctively, "Avadel") to provide me with access to d that my pharmacy providers may receive in the Program; (ii) conduct benefits based representative to access my Personal if needed, determine my eligibility for and facilitate quality and adverse event reporting ducational materials and information; (viii) contact behalf in connection with carrying out the my pharmacy providers may receive financial will no longer be protected by federal privacy tion, I will not be able to participate in the y cancel this Authorization at any time by calling P Support Services, P.O. Box 7613, Overland Park, and health plans, as well as Avadel, may no vious disclosures by them pursuant to this pating in the Program or until the Authorization is t I am entitled to receive a copy of this
*Patient/Guardian Signature		*Date
*Printed Patient/Guardian Name (First ar	nd Last)	Relationship, if applicable
Marketing Communications Opt-in (Optional): educational and informational communications fincluding text messages, prerecorded messages a products, services, and programs or other topics	from Avadel, its affiliates and agents by direct mai and phone calls, which may be sent via autodiale	l, email and to the phone number I provided, r, to provide me with information about Avadel



https://www.avadel.com/terms-and-conditions.



purchase of my prescribed medication. Text and data rates may apply. I may opt out at any time by texting "STOP". Additional terms apply: