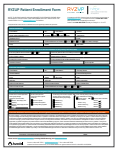
Paper/Fax Process

LUMRYZ New Patient Start Checklist

Lumryz™
(sodium oxybate) for extended-release oral suspension Ⓒ 4.5 | 6 | 7.5 | 9 g

☐ COMPLETE RYZUP PATIENT ENROLLMENT FORM



- Enter patient information
- Enter patient insurance information **(include copy of insurance card with fax)**
- Enter Prescriber Information, including **NPI and DEA numbers**
- Check box for patient diagnosis
- Check box starting dose *or* preferred titration schedule
- Obtain prescriber *or* authorized agent signature **(REQUIRED)**

☐ COMPLETE PATIENT AUTHORIZATION FORM

- Enter patient name, date of birth, and contact information
- **Obtain patient or guardian signature on form (REQUIRED)**

Fax both forms and copy of insurance card to RYZUP™ Support Services (877) 206-3198

☐ COMPLETE LUMRYZ REMS PATIENT ENROLLMENT FORM

- Enter patient information
- Enter Prescriber Information, including **NPI and DEA numbers**
- Check boxes on current/prior oxybate usage
- **Obtain patient or caregiver signature on form (REQUIRED)**
- Obtain Prescriber Signature **(REQUIRED)**

Fax LUMRYZ REMS Patient Enrollment Form to (877) 206-3198

☐ COMPLETE PRIOR AUTHORIZATION *(if necessary)*

- If a prior authorization is required, you will receive a CoverMyMeds® key code by fax
- Submit ePA through CoverMyMeds using key code provided or fax completed Prior Authorization form to patient's insurance plan

Fax Prior Authorization Determination (Approval/Denial) to (877) 206-3198

☐ COMPLETE LUMRYZ PRESCRIPTION FORM

- Once coverage is confirmed, we will provide your office with the LUMRYZ Prescription Form and indicate the LUMRYZ dispensing pharmacy that will process the prescription
- Refer to the LUMRYZ Prescription Form checklist on back page when filling out the LUMRYZ Prescription Form

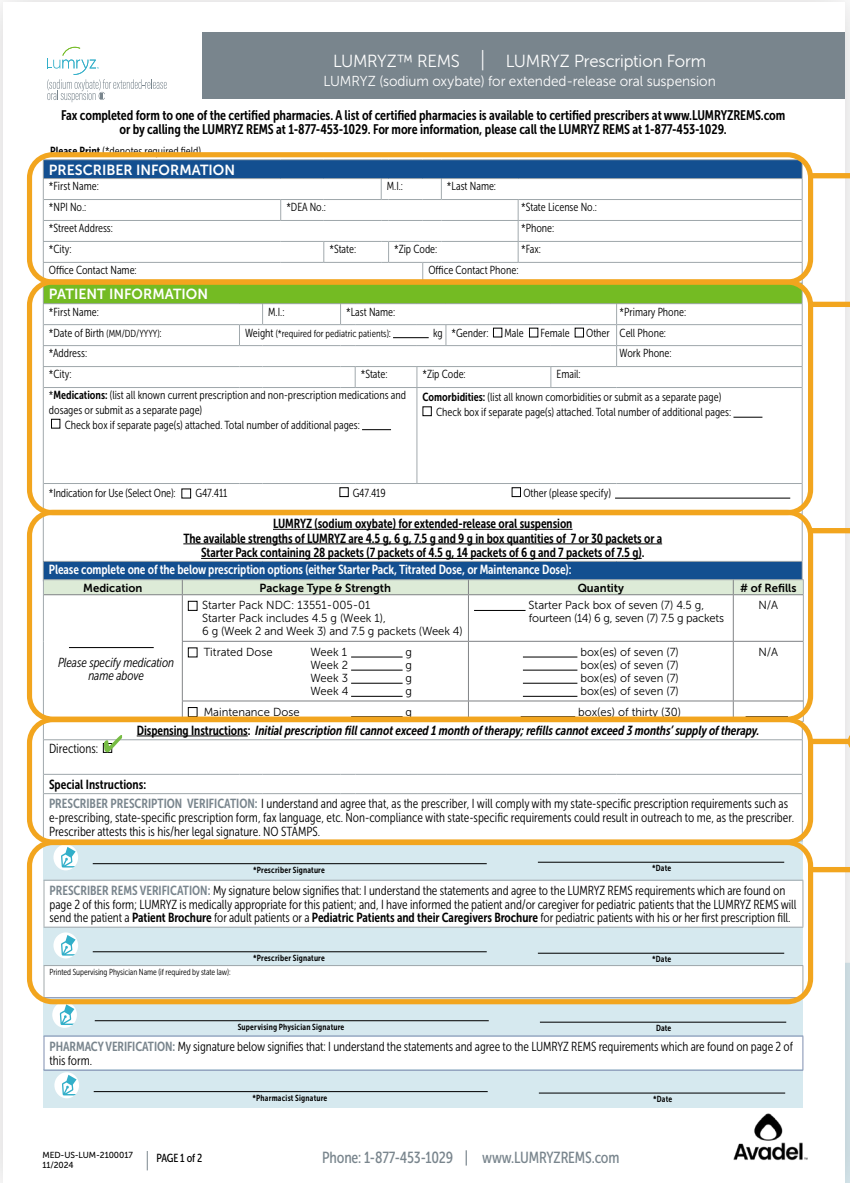
Fax LUMRYZ Prescription Form only after coverage confirmed

NPI, National Provider Identifier; DEA, Drug Enforcement Agency; REMS, Risk Evaluation and Mitigation Strategy; ePA, electronic prior authorization

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

LUMRYZ Prescription Form Checklist

Lumryz™
(sodium oxybate) for extended-release oral suspension Ⓒ 4.5 | 6 | 7.5 | 9 g



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

LUMRYZ™ REMS | LUMRYZ Prescription Form
LUMRYZ (sodium oxybate) for extended-release oral suspension

Fax completed form to one of the certified pharmacies. A list of certified pharmacies is available to certified prescribers at www.LUMRYZREMS.com or by calling the LUMRYZ REMS at 1-877-453-1029. For more information, please call the LUMRYZ REMS at 1-877-453-1029.

Please Print (*denotes required field)

PRESCRIBER INFORMATION

*First Name:	M.I.:	*Last Name:
*NPI No.:	*DEA No.:	*State License No.:
*Street Address:		*Phone:
*City:	*State: *Zip Code:	*Fax:
Office Contact Name:		Office Contact Phone:

PATIENT INFORMATION

*First Name:	M.I.:	*Last Name:	*Primary Phone:
*Date of Birth (MM/DD/YYYY):	Weight (*required for pediatric patients): _____ kg	*Gender: ☐ Male ☐ Female ☐ Other	Cell Phone:
*Address:			Work Phone:
*City:	*State:	*Zip Code:	Email:

*Medications: (list all known current prescription and non-prescription medications and dosages or submit as a separate page)
☐ Check box if separate page(s) attached. Total number of additional pages: _____

Comorbidities: (list all known comorbidities or submit as a separate page)
☐ Check box if separate page(s) attached. Total number of additional pages: _____

*Indication for Use (Select One): ☐ G47.411 ☐ G47.419 ☐ Other (please specify) _____

LUMRYZ (sodium oxybate) for extended-release oral suspension
The available strengths of LUMRYZ are 4.5 g, 6 g, 7.5 g and 9 g in box quantities of 7 or 30 packets or a Starter Pack containing 28 packets (7 packets of 4.5 g, 14 packets of 6 g and 7 packets of 7.5 g).

Please complete one of the below prescription options (either Starter Pack, Titrated Dose, or Maintenance Dose):

Medication	Package Type & Strength	Quantity	# of Refills
_____ *Please specify medication name above*	☐ Starter Pack NDC: 13551-005-01 Starter Pack includes 4.5 g (Week 1), 6 g (Week 2 and Week 3) and 7.5 g packets (Week 4)	_____ Starter Pack box of seven (7) 4.5 g, fourteen (14) 6 g, seven (7) 7.5 g packets	N/A
	☐ Titrated Dose Week 1 _____ g Week 2 _____ g Week 3 _____ g Week 4 _____ g	_____ box(es) of seven (7) _____ box(es) of seven (7) _____ box(es) of seven (7) _____ box(es) of seven (7)	N/A
	☐ Maintenance Dose _____ g	_____ box(es) of thirty (30)	

Dispensing Instructions: ***Initial prescription fill cannot exceed 1 month of therapy; refills cannot exceed 3 months' supply of therapy.***

Directions:

Special Instructions:

PRESCRIBER PRESCRIPTION VERIFICATION: I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. Prescriber attests this is his/her legal signature. NO STAMPS.

*Prescriber Signature _____ *Date _____

PRESCRIBER REMS VERIFICATION: My signature below signifies that: I understand the statements and agree to the LUMRYZ REMS requirements which are found on page 2 of this form; LUMRYZ is medically appropriate for this patient; and, I have informed the patient and/or caregiver for pediatric patients that the LUMRYZ REMS will send the patient a **Patient Brochure** for adult patients or a **Pediatric Patients and their Caregivers Brochure** for pediatric patients with his or her first prescription fill.

*Prescriber Signature _____ *Date _____

Printed Supervising Physician Name (if required by state law):

Supervising Physician Signature _____ Date _____

PHARMACY VERIFICATION: My signature below signifies that: I understand the statements and agree to the LUMRYZ REMS requirements which are found on page 2 of this form.

*Pharmacist Signature _____ *Date _____

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Phone: 1-877-453-1029 | www.LUMRYZREMS.com

Avadel.

- Enter prescriber information, **including NPI and DEA numbers**
- Enter patient demographic information
- Enter weight (for pediatric patients only)
- Complete medications and comorbidities sections
- **Write LUMRYZ in the medication box**
- Choose starter pack, custom titration schedule, or maintenance dose
- Enter quantity
- Enter refills for maintenance dose if needed
- **Check box** for Dispensing Instructions or provide Special Instructions in the box provided
- **Ensure prescriber signs and dates <u>both</u> signature lines (REQUIRED)**

! Fax signed and completed LUMRYZ Prescription Form to dispensing pharmacy indicated by RYZUP™ Support Services or your FRM. Submit e-prescription where required by law.

For informational purposes only; form is subject to change.

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

Avadel™