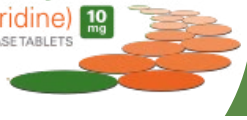
ampyra®
(dalfampridine) 10 mg
EXTENDED RELEASE TABLETS



AMPYRA® PATIENT ENROLLMENT FORM (APEF)

Please submit via escripts to 949-524-3566
To submit via fax at: 949-264-1199
For assistance please call **AMPYRA Patient Support Services** at: 855-866-9255

PLEASE COMPLETE ALL FIELDS TO AVOID ANY DELAYS IN PROCESSING.

PATIENT INFORMATION

First Name | MI | Last Name

Gender ☐ M ☐ F | DOB (mm/dd/yyyy)

Address (No PO Box)

City | State | Zip

Mobile Phone | Phone Type ☐ Home ☐ Cell ☐ Work

Alternate Phone | Email

INSURANCE INFORMATION

Please copy the front and back of the prescription drug and medical insurance cards and include with fax.

Prescription Drug Insurance ☐ Patient Has NO Prescription Drug Insurance

Prescription Insurer Name | Phone

ID # | BIN# | PCN# | Group #

ADDITIONAL INFORMATION

PAY AS LITTLE AS $0 CO-PAY FOR ELIGIBLE PATIENTS
(See details on page 2*)

☐ **Request for Co-pay Assistance only** ☐ **Request for Marketing Materials in Spanish.**

Please see page 2 for ***Patient Authorization and Signature.***

PRESCRIBER INFORMATION

Prescriber First and Last Name | NPI # | DEA #

Specialty: ☐ Neurology ☐ Other (Please specify):

Practice Name | Phone | Ext | Fax

Address

City | State | Zip

Office Contact Name | Contact Phone | Ext

Contact Fax | Email

PRESCRIPTION

Physician: If you are submitting the Rx through alternative means (eg. eScript through EHR). Do not fill in this box.

Rx: AMPYRA Extended Release Tablets, 10 mg

Sig: 1 tab po q12h

Other:

Dispense: ☐ 60 tablets (30 day supply) ☐ Refills: _____
☐ DAW1

Indicate ICD-10 Diagnosis:

☐ G35 Multiple Sclerosis
☐ Other Diagnosis Code

Allergies:

PRESCRIBER AUTHORIZATION

I certify that this therapy is medically necessary and that this is accurate to the best of my knowledge. I authorize Merz Therapeutics and the entities that operate its patient support hub, Patient Support Services (collectively, "Merz"), to use and disclose the patient information herein contained to the patient's insurers and pharmacies and to obtain information, including protected health information (as defined in 45 CFR § 160.103), from the patient, or from the patient's insurer or pharmacy, to facilitate dispensing as well as the patient's enrollment and participation in services offered by Patient Support Services in a manner consistent with the HIPAA minimum necessary standard. I authorize Merz to contact the patient to report insurance coverage information, to inform the patient about the financial assistance programs offered by Merz, and to obtain any patient consent(s) that may be necessary in order to support the patient's treatment with Ampyra as prescribed by me. I authorize Merz to transmit the above prescription to the pharmacy.

Prescriber Signature ***(Manual signature and date required)***

Dispense as Written | Date

OR

Substitution Permissible | Date

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Patient Authorization

By signing this form, I (as applicable, Patient or Patient's Legal Guardian [Guardian] if patient is a minor) understand that RIS RX, LLC (Administrator) is administering the AMPYRA Patient Savings Program (Program) on behalf of Merz Pharmaceuticals, LLC (Merz). Administrator will review patient Application form and determine my/patient's eligibility for the Program based on the information provided. Administrator may, at any time require additional information to determine or confirm my/patient's eligibility/ Administrator will notify me if I am/patient is eligible and may provide me with additional information. I agree to notify the Program by way of email to merz@RISRx.com within thirty (30) days of any changes to the information provided on this Enrollment Form. I understand that my failure to notify the Program of any changes may result in my removal from the Program.

HIPAA Authorization to Use and Disclose Information

By signing below and submitting this Application, I understand and authorize my/the patient's health care provider and health insurer to release my/the patient's protected health information, including information contained in this Application or my/the patient's medical records or benefits information and/or any and all information related to my medical condition, to Administrator and to Merz (Administrator/Merz) and authorize Administrator/Merz to contact me in connection with this Program. Further, I authorize Administrator/Merz to contact my/the patient's insurer and physician to confirm coverage for AMPYRA and eligibility for this Program. I authorize Administrator/Merz to use my/ the patient's information to administer the Program and to communicate with me, my/patient's physician, and my/patient's insurer. I understand that participation in the Program is voluntary and my/patient's health care provider or insurer may not require me to sign this authorization as a condition of treatment or coverage; however, if I do not sign this authorization, I/the patient will be unable to participate in the Program. This authorization will be valid if I am enrolled in the Program, unless a shorter time is required by applicable law. I also understand and agree: (i) I can obtain a copy of this signed authorization; (ii) I/the patient may revoke this authorization in writing at any time by email to patientsupportservices@RISRx.com, but I/patient will no longer be permitted to participate in the Program after the date the authorization is revoked and my revocation will not impact uses or disclosures of information already made in reliance on this authorization; and (iii) once my/the patient's protected health information has been disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.

I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Merz Therapeutics, Inc., P.O. BOX 1457 Newport Beach, CA 92659 but that this cancellation will not apply to any information already used or disclosed pursuant to this authorization before notice of the cancellation is received by each of the Entities.

This authorization expires ten (10) years from the date of execution or upon such earlier date as may be mandated by state law, if applicable.

Patient or Guardian/Legal Representative Signature ***(Signature and date required for services)***

Print Name

Date

*Co-pay Program Eligibility, Terms and Conditions, and Program Limitations

Patients must:

- Be 18 years of age or older
- Be prescribed AMPYRA for an FDA-approved indication
- Have commercial health insurance
- Not covered by any federal, state, or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, Veterans Affairs, Department of Defense, or TRICARE

This offer is valid only in the United States, excluding where its otherwise prohibited by law. Patients residing in the states of Massachusetts and Rhode Island are eligible for drug co-payment assistance only and are not eligible for other types of co-payment assistance, including but not limited to costs related to administration of the drug.

Patients who move from commercial to federally funded or state funded insurance will no longer be eligible for the program. Proof required for receiving payment for out-of-pocket drug costs includes a valid explanation of benefits (EOB) or specialty pharmacy invoice, which must be submitted with 180 days after each treatment.

Patient/Guardian may not and agrees not to seek reimbursement for value received from the Program from any third-party payers, including flexible spending accounts or healthcare savings accounts. If at any time patient begins receiving coverage under any federal, state, or government funded healthcare program, Patient is no longer eligible to participate in the Program and must call 855-866-9255 between 8am – 8pm ET to stop participation. Restrictions may apply. This is not health insurance. Patient/Guardian and pharmacist are responsible for notifying insurance carriers or any other third party who pays for or reimburses any part of the prescription filled using the Program as may be required by the insurance carrier's terms and conditions and applicable law.

Once a patient is successfully enrolled into the Program, they will be automatically re-enrolled annually, for as long as your patient remains eligible. The patient is obligated to notify the program within thirty (30) days of any change in information provided in patient's enrollment form. The patient may notify the Program at any time to terminate participation in the Program. The patient may submit a new enrollment form to make changes to any Program elections. This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer for AMPYRA.

This is a limited time offer, and Merz reserves the right to rescind, revoke, amend, or terminate this offer, or the program in its entirety, at any time without notice.

Patient Marketing Consent

☐ By checking this box, I authorize Merz or parties acting on its behalf to use my protected health information for marketing activities or to contact me/the patient in the future for market research, clinical trials, and other information it believes to be of interest to me/ the patient. (participation optional)

Initial Here

The signature also denotes that I authorize Patient Support Services to leave information regarding my AMPYRA prescription, insurance coverage, and Specialty Pharmacy Provider on my answering machine or voicemail (participation optional).

What you need to know to receive your AMPYRA delivery

Ask your doctor to include specific language such as "Dispense As Written" (DAW 1) on every one of your AMPYRA prescriptions including refills to ensure you receive your branded AMPYRA.

AMPYRA Patient Support Services Center will contact you to verify your insurance and co-pay amount. To verify your insurance and co-pay amount, **you must speak to the representative who calls.**

These calls may be from an unrecognizable 844 phone number.

A Pharmacy will call to arrange your AMPYRA delivery. To receive your AMPYRA **you will need to speak to the representative** who calls you to confirm your shipment.

These calls may be from unrecognizable 800/888 phone numbers.

Have questions? Call AMPYRA Patient Support Services toll-free 855-866-9255 Monday through Friday, 8 am to 8 pm EST.

Please see the Full Prescribing Information available at www.ampyra.com/prescribing-information.pdf.