AMPYRA® Patient Support Services Center

Prescription & Service Request Form

Fax completed form to 888-883-3053 Phone 888-881-1918

Please complete all fields to avoid any delays in processing.

Free 60 Day Trial

ampyra® (dalfampridine) 10 mg EXTENDED RELEASE TABLETS

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____ Sex: ☐M ☐F

Email: _____ Last 4 Digits of SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION

Prescription Drug Insurer: _____ ID #: _____ BIN #: _____ PCN #: _____

Group #: _____ Phone: _____ Preferred Specialty Pharmacy: _____

Primary Medical Insurance: _____ Cardholder Name: _____

Relationship to Cardholder: ☐self ☐spouse ☐child ☐other ID#: _____ Group #: _____ Phone: _____

Secondary Medical Insurance: _____ Cardholder Name: _____

Relationship to Cardholder: ☐self ☐spouse ☐child ☐other ID#: _____ Group #: _____ Phone: _____

☐ Patient does not have insurance

PATIENT AUTHORIZATION

I have read and agree to the attached **Patient Authorization Section A (Signature and Date Required).**

X _____

Patient Signature ***Date***

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

Initial Here ☐ The signature to the left also denotes that I have read and agree to the attached **Patient Marketing Consent Section B** (participation optional).

FOR OFFICE USE ONLY

PRESCRIBER INFORMATION

Prescriber's Name: _____ Specialty: Neurology ☐Yes ☐No Other: _____

Practice Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact Name: _____ Contact Phone: _____ NPI #: _____

☐ I authorize Ampyra Patient Support Services to contact patient directly to obtain patient signature.

60 DAY TRIAL PRESCRIPTION

Free 60 Day Trial Enrollment

Patients with Medicaid, Medicare Part D, or other government funded coverage are not eligible.
For eligibility requirements go to www.ampyra.com.

I request that Acorda provide two 60 count bottles of AMPYRA Extended Release Tablets, 10 mg.

Sig: **1 tab po q12h**

I certify that this therapy is medically necessary and that this is accurate to the best of my knowledge. **(Signature and Date Required)**

X _____

Prescriber Signature ***Date***

PRESCRIPTION

Standard Continuing Prescription

Rx: AMPYRA Extended Release Tablets, 10 mg

Sig: **1 tab po q12h**

Other: _____

Dispense: ☐ 180 tablets (90 day supply) Refills: ___

☐ _____ Refills: ___

Indicate Diagnosis:
☐ G35 Multiple Sclerosis
☐ Other: _____

I certify that this therapy is medically necessary and that this is accurate to the best of my knowledge. I authorize the Lash Group, Inc. ("Lash") as the operator of the AMPYRA Patient Support Services Center on behalf of Acorda Therapeutics, Inc. ("Acorda") to be my designated agent and to act for me, a covered entity, as my business associate (as those terms are defined in 45 CFR § 160.103) to use and disclose any information about any of my patients enrolled with the AMPYRA Patient Support Services Center to such patients' insurers and pharmacies and to obtain any information about such patients, including any protected health information (as defined in 45 CFR § 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes in a manner consistent with the HIPAA minimum necessary standard. I authorize Lash to contact patients to report coverage information and to inform them about the financial assistance programs offered by Acorda. Lash may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR § 164.514(b). As my business associate, Lash is required to comply with, and by my signature hereto I agree to comply with the terms of the Business Associate Agreement ("BAA") at www.lashgroup.com/BAA and Lash will safeguard any protected health information that it obtains from me or on my behalf, and will use and disclose this information only for the purposes specified in such BAA or as otherwise permitted by law.

X _____

Prescriber Signature - Dispense As Written ***Date***

_____

Handwrite above as applicable by state: ***Date***
Brand Medically Necessary/Dispense As Written/Do Not Substitute

_____

Substitution Permitted ***Date***

CLINICAL INFORMATION *(recommended)*

☐ Patient is ambulatory Baseline T25FW _____ Seconds Date completed: _____

Patient's EDSS Score: _____ Concomitant Medications, if any: _____

History of Seizure: ☐Yes ☐No Patient Weight: _____ ☐kg ☐lbs Patient Allergies: _____

Moderate or Severe Renal Impairment: (CrCl ≤ 50 mL/min): ☐Yes ☐No Serum Creatinine: _____ mg/dL

Estimated CrCl: _____ mL/min. CrCl can be estimated using the following equation (multiply by 0.85 for women): CrCl = [(140-age) x weight (kg)]/[SerumCr (mg/dl) x 72]

Please see Indication and Important Safety Information on reverse side.

ampyra®
(dalfampridine) 10 mg
EXTENDED RELEASE TABLETS

Indication:
AMPYRA® (dalfampridine) is indicated to improve walking in adults with multiple sclerosis (MS). This was demonstrated by an increase in walking speed.

Important Safety Information:

- AMPYRA is contraindicated in patients with history of seizure, moderate or severe renal impairment (CrCl ≤ 50 mL/min), or history of hypersensitivity to AMPYRA or 4-aminopyridine.
- AMPYRA can cause seizures. The risk of seizures increases with increasing doses. Permanently discontinue AMPYRA if seizure occurs. In the post-marketing period seizures have been reported. The majority of seizures occurred at the recommended dose, in patients without a history of seizures, and generally within days to weeks of starting therapy.
- AMPYRA has not been evaluated in patients with history of seizures or with epileptiform activity on an EEG, as these patients were excluded from clinical trials. The risk of seizures in patients with epileptiform activity on an EEG is unknown, and could be substantially higher than that observed in clinical studies.
- Avoid concomitant use of AMPYRA with other forms of 4-aminopyridine (4-AP, fampridine), since the active ingredient is the same. Instruct patients to discontinue use of any product containing 4-AP prior to initiating AMPYRA to reduce the potential for dose-related adverse reactions.
- AMPYRA can cause anaphylaxis and severe allergic reaction. Signs and symptoms included respiratory compromise, urticaria, and angioedema of the throat or tongue. If an anaphylactic or other serious allergic reaction occurs, permanently discontinue AMPYRA.
- AMPYRA is cleared predominantly by the kidneys. The risk of seizures in patients with mild renal impairment (CrCl 51–80 mL/min) is unknown, but AMPYRA plasma levels in these patients may approach those seen at a dose of 15 mg twice daily, a dose that may be associated with an increased risk of seizures. Estimated CrCl should be known before initiating AMPYRA and monitored at least annually during treatment.
- The most common adverse reactions (incidence ≥ 2% and at a rate greater than placebo) for AMPYRA in MS patients were urinary tract infection, insomnia, dizziness, headache, nausea, asthenia, back pain, balance disorder, multiple sclerosis relapse, paresthesia, nasopharyngitis, constipation, dyspepsia, and pharyngolaryngeal pain.
- The risk of adverse reactions, including seizures, increases with increasing AMPYRA doses. There is no evidence of additional benefit at doses greater than 10 mg twice daily.
- Concomitant use with OCT2 inhibitors (e.g., cimetidine) may cause increased exposure to AMPYRA and potential risk of seizures.
- There are no adequate and well-controlled studies of AMPYRA in pregnant women. AMPYRA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- It is not known if AMPYRA passes into breast milk. Discontinue AMPYRA or nursing, taking into consideration the importance of AMPYRA to the mother.
- Safety and effectiveness of AMPYRA in patients younger than 18 years have not been established.
- Clinical studies of AMPYRA did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Because elderly patients are more likely to have decreased renal function, it is important to know the estimated CrCl before initiating AMPYRA.

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

AMPYRA® Patient Support Services Center
Phone 888-881-1918

Please read the following statements carefully, then sign and date where indicated on the previous page.

ampyra® (dalfampridine) 10 mg EXTENDED RELEASE TABLETS

A. PATIENT AUTHORIZATION

By signing this authorization, I authorize my health plans, physicians, and pharmacies (collectively, my "Providers") to disclose my personal health information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription (collectively, "Personal Health Information"), to Acorda Therapeutics, Inc. ("Acorda") and its representatives, agents, and contractors, including but not limited to Acorda's AMPYRA Patient Support Services Center operated by The Lash Group, Inc. on behalf of Acorda (collectively "the Entities") for purposes of (1) providing services to me by the AMPYRA Patient Support Services Center; (2) facilitating the provision of products, supplies or services by Acorda; (3) registering me in any applicable Acorda product registration program; (4) evaluating the effectiveness of Acorda's AMPYRA education programs and (5) enrolling me in Acorda's Free 60 Day Trial, patient assistance program, and/or copay mitigation program (if one or more such programs apply to me). I understand that my pharmacies will disclose to the Entities certain personal health information regarding the dispensing of my Ampyra prescription and that such disclosure will result in remuneration to my pharmacies. I understand that once my Personal Health Information is disclosed to the Entities under this authorization, it is no longer protected by Federal privacy laws and may be further disclosed by the Entities; however, Acorda agrees to protect my information and only use and/or disclose it for the purposes described above, or as I may further authorize in writing, or as permitted or required by law. I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I may not be able to receive assistance through the AMPYRA Patient Support Services Center. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Acorda Therapeutics, Inc., 1800 Innovation Point, Fort Mill, SC 29715, but that this cancellation will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by each of the Entities. This authorization expires ten (10) years from the date signed on the previous page.

B. PATIENT MARKETING CONSENT

I further authorize the release of information provided in this enrollment form to Acorda Therapeutics, Inc. ("Acorda") for the provision of education, training, and ongoing support on the use of AMPYRA. Acorda may provide me with educational or product-related informational materials. The Lash Group, Inc., which operates the AMPYRA Patient Support Services Center for Acorda, may receive compensation from Acorda for providing such services. I authorize Acorda to contact me with promotional materials related to my treatment, to use and give out my information to send me information or materials related to AMPYRA or any other related products or services in which I might be interested, to contact me occasionally to obtain feedback (for market research purposes) about Acorda, AMPYRA, or the AMPYRA Patient Support Services Center, to operate (and improve the quality of) the AMPYRA program, or otherwise as required or permitted by law. If I do not wish to receive information related to AMPYRA or any related products or services or to be contacted occasionally for market research purposes, I understand that I may call the AMPYRA Patient Support Services Center's toll-free number, 888-881-1918 at any time.

What You Need to Do to Receive Your AMPYRA® Delivery

Ask your doctor to include specific language such as "Dispense As Written" (DAW) 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 unrecognizable 800/888 phone numbers.

A Pharmacy will call to arrange your AMPYRA delivery. To receive your AMPYRA, **you must 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 1-888-881-1918 Monday through Friday, from 8 AM to 8 PM ET.