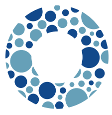

Patient Enrollment Form

1-866-750-9516 1-833-OSMOLEX (1-833-676-6539)

ATTN Prescriber: Please ensure you fax this signed and dated Patient Enrollment Form along with the completed AccessOsmolex Enrollment and Prescription Form to 1-866-750-9516.

Patient Authorization

Please read the following carefully, then sign and date where indicated below.

I authorize Adamas Pharmaceuticals, Inc. ("Adamas") and its service providers to use and disclose my protected health information ("PHI") to provide me with support services related to Adamas products. I understand these services may include, but are not limited to, online support, financial assistance, compliance and persistency and other treatment services, and information or materials related to such services. Services may also include marketing materials about Adamas products; information about Adamas products, Adamas' services, and disease states or conditions relating to Adamas' products; and market research related to Adamas products or questions about my experience with, or thoughts on, Adamas' products or services. I understand that any person providing such services is working on behalf of Adamas and is not employed by, or working on behalf of, my healthcare provider(s).

I authorize Adamas **and its service providers to contact me to provide such services and information by mail, email, fax, telephone call, and text messages, using the contact information I provide on the AccessOsmolex Enrollment Form.** I also authorize Adamas and its service providers to use my PHI in connection with the services, including, without limitation, sharing information with my healthcare provider(s), insurance provider, pharmacy, and specific individuals that are identified on the AccessOsmolex Enrollment Form.

I authorize my healthcare provider(s), pharmacy, and my health plan(s) to share information about me or my medical condition, including my PHI, with Adamas and its service providers, which may administer AccessOsmolex. I authorize Adamas and its service providers to use and share this information to determine whether I am eligible for insurance coverage or other reimbursement for the Adamas products that my healthcare provider has prescribed for me, to determine whether I am eligible for AccessOsmolex services, to administer AccessOsmolex services, and to assess the quality of AccessOsmolex services.

I understand that pharmacies may receive payment from Adamas in connection with the use and disclosure of my PHI as described in this Authorization. I further authorize pharmacies to use my PHI to communicate with me about OSMOLEX ER and provide other services described in this Authorization and understand that they may receive a fee for such communications and services. I understand that I do not have to agree to receive these services and communications in order to receive OSMOLEX ER, as prescribed by my physician.

I certify that I am at least eighteen (18) years of age. I understand that my healthcare provider(s), pharmacy, and my health plan(s) may not condition current or future treatment, payment, or eligibility for benefits on whether I sign this Authorization. **I understand that I may revoke my authorization and choose not to receive services or information from Adamas by notifying a program representative by telephone (1-833-676-6539). I understand that if I revoke this Authorization, the revocation will not apply to any information already used or disclosed pursuant to this Authorization, and that I will no longer be able to receive AccessOsmolex services.** This Authorization expires on the specific date when I stop receiving services from AccessOsmolex unless otherwise required by law.

CANNOT process form without this section completed

☐ **I have read and agree to the Patient Authorization above.**

Patient's Signature ______________________________ Date ______________

Print Patient's Name ______________________________

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