Osmolex®ER (amantadine) Extended-release Tablets

Enrollment and Prescription Form

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

ACCESS Osmolex™ SUPPORT CENTER

1 Patient Information

First Name _____ MI _____ Last Name _____

DOB (mm/dd/yyyy) _____ / _____ / _____ ☐ Male ☐ Female ☐ Long-Term Care Facility

Street Address _____

City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____

2 Patient Insurance Information

Please include a copy of the front and back of patient's prescription insurance card(s).

3 Healthcare Provider Information

HCP Name _____ ☐ MD ☐ DO ☐ PA ☐ NP

State License # _____ Physician NPI # _____

Office Name _____ Phone _____ Fax _____

Street Address _____

City _____ State _____ Zip _____

Office Contact Name _____

Office Contact Phone _____ Office Contact Email _____

4 Medical Information

Has the Patient Been Prescribed Amantadine IR? **Patient's Diagnosis Code** _____

☐ Yes Date of last use _____ ☐ No

Patient Received Samples ☐ Yes ☐ No **Sample Dose and Days Supply** _____

5 OSMOLEX ER Prescription Information

TITRATION DOSE* – 1st FILL
OSMOLEX ER (amantadine)

☐ 129 mg ☐ 193 mg ☐ 258 mg

Directions _____

_____

Quantity _____ Refills 0

*Use if intending to titrate

MAINTENANCE DOSE – 2nd FILL
OSMOLEX ER (amantadine)

☐ 129 mg ☐ 193 mg ☐ 258 mg ☐ 322 mg†

Directions _____

_____

Quantity _____ Refills _____

†322 mg dose dispensed as a 129 mg tablet + 193 mg tablet

6 Prescriber Signature

I certify that the above therapy is medically necessary and that the information provided is accurate, to the best of my knowledge. I certify that I am the prescriber who has prescribed OSMOLEX ER to the above-named patient and that I provided the patient with the full Prescribing Information for OSMOLEX ER. I authorize Adamas Pharmaceuticals, Inc. and its affiliates, agents, representatives, and service providers to: (1) forward this prescription to a dispensing pharmacy that will dispense the medication to the above-named patient; (2) process this Enrollment and Prescription Form and verify the information contained in this Application; and (3) administer, analyze, and improve the AccessOsmolex™ program, which includes comprehensive patient support services, such as benefits investigation and related coverage and reimbursement services to allow AccessOsmolex™ to help to ensure that the patient is able to appropriately access the drug that I have prescribed. I confirm that I have secured all necessary authorizations and consents so that I may share the patient's health information with Adamas Pharmaceuticals, Inc. and its affiliates, agents, representatives, and service providers.
Prescriber authorizes UBC to use the Surescripts network on Prescriber's behalf in connection with this enrollment form. Prescriber will comply with all Surescripts' terms and conditions available at https://ubc.com/surescriptsterms/. All Surescripts disclaimers apply.

Prescriber Signature _____ Date _____

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