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

†258 mg dose dispensed as a 129 mg tablet + 129 mg tablet

**MAINTENANCE DOSE – 2nd FILL**
**OSMOLEX ER (amantadine)**

☐ 129 mg ☐ 193 mg ☐ 258 mg‡ ☐ 322 mg§

Directions _____

_____

Quantity _____ Refills _____

‡258 mg dose dispensed as a 129 mg tablet + 129 mg tablet

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

## 6 Prescriber Signature

I certify that the information provided in this OSMOLEX ER Prescription Form is complete and accurate to the best of my knowledge. I have prescribed OSMOLEX ER based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Adamas Pharmaceuticals, Inc. (Adamas), and Adamas for benefits eligibility, coverage authorization, coordination and dispensing of OSMOLEX ER, and providing me and my patient with other educational and support services associated with OSMOLEX ER. I authorize the forwarding of this prescription and the information to a dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program.

Prescriber Signature _____ Date _____

ADAMAS

Distributed by: Adamas Pharmaceuticals, Inc.
Emeryville, CA 94608
www.adamaspharma.com
Customer Service: 1 833 223-2627