NOURIANZ™ (istradefylline) Prescription & Enrollment Form

Phone: 833-KK-CARES (833-552-2737) | Fax: 833-447-4399 | M-F, 8AM to 8PM EST
Mailing Address: 4700 Millenia Boulevard, Suite 500, Orlando, FL 32839

*Indicates a required field

1. Patient Information

*Patient First Name: _____ *MI: _____

*Patient Last Name: _____

*DOB: _____ *Gender: ☐ M ☐ F ☐ Unspecified

*Resident of the US or Puerto Rico: ☐ Yes ☐ No

*Preferred Language: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

*Home Phone: _____ Cell Phone: _____

Email: _____

Caregiver Name: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Email

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

2. Patient Insurance Information

Please Attach Copies of Front & Back of Cards for Pharmacy and Medical Insurance Plans

*Policy Holder Name: _____

Relationship to Patient: _____

*Pharmacy Insurance Name: _____

*Pharmacy Group #: _____ *Pharmacy ID #: _____

*Rx BIN: _____ *Rx PCN: _____

Pharmacy Plan Phone #: _____

*Medical Insurance Name: _____

*Medical Plan ID #: _____ *Medical Group #: _____

Phone #: _____

Plan Type: ☐ Private / Commercial ☐ Medicaid ☐ Medicare Part D

☐ Medicare Advantage ☐ VA or Military ☐ None- Uninsured

3. Prescriber Information

*Prescriber Name: _____ ☐ MD ☐ NP ☐ DO ☐ PA

Prescriber NPI #: _____

Facility Name: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone #: _____ Fax #: _____

*Office Contact Name: _____

Office Contact Email: _____

4. Clinical Information

*ICD 10: ☐ G20 Parkinson's Disease ☐ Other _____

*Allergies: _____

*Is the patient currently taking Levodopa/Carbidopa?: ☐ Yes ☐ No

*Current Meds: _____

_____

5. Prescriber Certification

I certify that the information in this Prescription & Enrollment Form is complete and accurate to the best of my knowledge. By signing this Prescription & Enrollment Form below I certify that I have prescribed NOURIANZ™ based on my professional judgment of medical necessity, and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to NOURIANZ™ therapy to agents, and service providers of Kyowa Kirin (including but not limited to and NOURIANZ™ dispensing pharmacies) to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the named patient for the purpose of verifying benefit eligibility and obtaining coverage authorization.

6. Free 28-Day Quick Start NOURIANZ™

Rx: NOURIANZ™

Quick Start Rx available one time for patients within labeled indication only for a max fill of 28 days. Not contingent on purchase of any kind. Quick Start Rx may not be submitted for reimbursement to any third party payer. We reserve the right to modify or terminate the program without notice at any time. See complete Quick Start terms and conditions at www.KyowaKirinCares.com

By signing below, I authorize ARx Patient Solutions Pharmacy to dispense a free up to 28 day Quick Start Rx.

Dispense: (Please select one option below)

☐ 20 mg tablets ☐ 40 mg tablets Qty: 28

SIG: Take one (1) tablet daily

Please sign and date below:

*Dispense As Written: _____

*Substitution Permitted: _____

*Date: _____

7. Prescription for NOURIANZ™

Rx: NOURIANZ™

Dispense: (Please select one option below)

☐ 20 mg tablets or ☐ 40 mg tablets

Quantity: ☐ 30 tablets ☐ 90 tablets ☐ ___ tablets

SIG: Take one (1) tablet daily Refills #: _____

Please sign and date below:

*Dispense As Written: _____

*Substitution Permitted: _____

*Date: _____

*STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY -*If required by applicable law, please attach copies of all prescriptions on official state prescription forms*

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Patient Name: _____ DOB: _____

** Indicates a required field*

8. Patient Authorization and Agreement

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for NOURIANZ™ and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Kyowa Kirin, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Kyowa Kirin") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting Kyowa Kirin Cares Support Services (the "Program") for Healthcare Providers and patients for the purposes described below.

a. Specifically, I authorize disclosure of my Protected Health Information in order to:

b. Enroll me in, and contact me about the Program, including online support, financial assistance services, co-pay assistance, nurse services, compliance and persistency services, and electronic communication including emails and text messages,

c. Communicate with my Healthcare Providers and Insurers about benefits, coverage and medical care, including compliance with Product treatments,

d. Locate a specialty pharmacy that can fill my prescription and facilitate dispensing of my prescription by such pharmacy,

e. Provide me with educational materials, information and services related to my treatment experience with NOURIANZ™ and my condition,

f. Contact me and leave messages about my use of NOURIANZ™ and my medical care,

g. Verify, investigate, assist with, and coordinate my coverage for NOURIANZ™ with my Insurers,

h. Coordinate prescription fulfillment and share prescription information,

i. Conduct surveys, data analytics, market research and other internal business activities related to the Program, NOURIANZ™, and other Kyowa Kirin products and programs, and

j. Contact me as otherwise required or permitted by law.

I understand that pharmacies that ship my medication may be paid to share this information with the Program to help provide the offerings requested for me. Once my Protected Health Information has been disclosed to Kyowa Kirin, I understand that federal privacy laws no longer protect the information. However, Kyowa Kirin agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law.

I understand that I am providing 'written instructions' to Kyowa Kirin and its vendor AssistRx under the Fair Credit Reporting Act authorizing AssistRx on behalf of Kyowa Kirin to obtain information from my credit profile or other information from consumer credit agencies. I authorize Kyowa Kirin and its partnered provider AssistRx to obtain such information solely for the purpose of determining financial qualifications for the Program. I understand that I must affirmatively agree to the terms in this notice by signing below in order to proceed in the Program financial screening process.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided by Kyowa Kirin under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

This Authorization will last for a period of five (5) years (unless earlier termination is required by applicable state law). I understand that I may cancel this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by mailing a request to 4700 Millenia Boulevard, Suite 500, Orlando, FL 32839, via fax at 833-447-4399, or by calling 833-552-2737. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

The personal and health insurance I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this Form changes by contacting the Program at 833-552-2737.

My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

*Patient Name: _____ *Signature: _____ *Date: _____
Please Print

9. Patient Authorized Representative

I permit Kyowa Kirin Cares Support Services representatives to speak with the following person about this enrollment form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, insurance appeals, or any other treatment related issues. I may cancel this authorization at any time by calling: 833-552-2737.

Name of Authorized Representative: _____ Relationship to Patient: _____

Phone Number: _____ Email: _____

By signing below, I, the patient named above, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

*Signature: _____ *Date: _____