Trokendi XR Service Request Form

Fax completed form to Supernus Support at 1-855-998-1515
Phone: 1-866-398-0833 ■ www.TrokendiXR.com

Trokendi XR® (Topiramate)
extended-release tablets

STEP 1: Patient Information

Name:____________________

Sex: ☐Male ☐Female Date of Birth: __________

Address:____________________

City:__________ State:________ Zip Code: __________

Phone:__________ Mobile Phone: __________

Alternate Phone:__________ Email: __________

Pref. Communication: ☐Mobile ☐Alt. Phone ☐Text ☐Email

Best Time to Contact: ☐Morning ☐Afternoon ☐Evening

Person Authorized to Speak on Your Behalf: __________

Patient's Preferred Language: __________

Patient Insurance: Complete the information below. Please Attach Insurance Cards.

Does Patient Have Insurance: ☐Yes ☐No Patient's Pharmacy: __________

Health Plan Insurer:__________ Rx Plan:__________

Member ID #: __________ Rx Member ID #: __________

Plan Phone #:__________ Rx Plan Phone #: __________

Cardholder Name: __________ Cardholder DOB: __________

Relationship to Cardholder: ☐Self ☐Spouse ☐Child ☐Other

STEP 2: Read and Sign Patient Authorization

I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Supernus Pharmaceuticals and companies working with Supernus Pharmaceuticals, which may be branded as SupernusSupport™ (collectively, "Supernus Pharmaceuticals"), my contact information, health information relating to my medical condition to the extent necessary to support treatment that may also include identifying any potential drug interactions evaluation and allergies, and insurance coverage for Supernus Pharmaceuticals to (i) provide me with support services (which may be branded as SupernusSupport™) and related information and materials on any of Supernus Pharmaceuticals products, including, but not limited to, educational support provided in-person, on-line or by telephone, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided, and (iii) provide me with information about Supernus Pharmaceuticals products, services, and programs and other topics of interest for marketing, educational or other purposes. Once my health information has been disclosed to Supernus Pharmaceuticals, I understand that Federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Supernus Pharmaceuticals. However, Supernus Pharmaceuticals agrees to protect my health information by using and disclosing it only for purposes authorized in this Patient Authorization and Consent or as required by law or regulations. I understand that I may refuse to sign this Authorization, and I further understand that my treatment (including with a Supernus Pharmaceuticals product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign this Authorization, or later cancel it, I will not be able to receive any support services from Supernus Pharmaceuticals including those branded as SupernusSupport™. I may cancel this Authorization at any time by emailing a letter to: SupernusSupport@PharmaCord.com. Canceling this Authorization will end my consent to further disclose health information to Supernus Pharmaceuticals by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Authorization expires December 31, 2028 or such shorter time-frame required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I have read, understand, and agree to the terms in section I above, Authorization to Share Health Information.

Signature: ____________________

Relationship to Patient: __________ Date: __________

STEP 3: Prescriber Information

Prescriber Name: ____________________

Specialty: ☐Neurology Other: __________

Practice Name____________________

Prescriber Address: __________City:__________

State:________ Zip Code:________ Medicaid #:________NPI #:________

Phone:__________Fax:__________ State Lic. #: __________

Physician Office Contact:__________Email:__________

Pref. Communication: ☐Mobile ☐Alt. Phone ☐Text ☐Email

STEP 4: Medical & Prescription Information

☐G43.909 ☐G43.009 ☐G43.709 ☐G43.719 ☐R51

Other Diagnosis Code:__________ ☐No Known Drug Allergies

Allergies: __________

Anticonvulsant/Migraine Medications Currently Taking:

1. __________ 2. __________

Concurrent Medications: __________

Anticonvulsant/Migraine Medications Previously Tried and Failed, with Reason for Discontinuation:

	Medications	Reason	Date of Discontinuation
1.	__________	__________	__________
2.	__________	__________	__________

Weight: __________ Height: __________ BMI: __________

		Directions	Qty	Refills
Trokendi XR®	☐25mg ☐100mg ☐50mg ☐200mg			

I certify that this therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the physician that has prescribed Trokendi XR® to the previously identified patient. I authorize PharmaCord® on behalf of my patient to facilitate processes to assist the patient in obtaining Trokendi XR® as indicated on this prescription.

Prescriber Signature: ____________________ Date: __________

Original Signature of Prescriber ☐ **Dispense as Written** **Invalid Without Date**

Please fax to 1-855-998-1515

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