

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® | <input type="checkbox"/> 25mg <input type="checkbox"/> 100mg <input type="checkbox"/> 50mg <input type="checkbox"/> 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**