Supernus® Support Enrollment Form for Trokendi XR®

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

Supernus® Support

BENEFIT VERIFICATION

☐ Complete sections A,B,C,D&F.

Prescriber Signature (D) and Patient Signature (F) required.

PATIENT ASSISTANCE PROGRAM

☐ Complete all sections.

All signatures required (D,E and F).

A PATIENT INFORMATION

NAME: (First, Middle, Last)	SUFFIX:	SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH:
ADDRESS:	CITY:	STATE:	ZIP:
PHONE: - -	MOBILE PHONE: - -	EMAIL:	
PREFERRED COMMUNICATION: ☐ MOBILE ☐ PHONE ☐ TEXT ☐ EMAIL		BEST TIME TO CONTACT: ☐ AM ☐ PM	
PERSON AUTHORIZED TO SPEAK ON YOUR BEHALF:		PATIENT PREFERRED LANGUAGE:	

B PATIENT INSURANCE (Complete the fields below or provide copies of insurance cards).

DOES PATIENT HAVE INSURANCE: ☐ YES ☐ NO	PATIENT PHARMACY:	DOES PATIENT HAVE PRESCRIPTION INSURANCE: ☐ YES ☐ NO
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:		

C PRESCRIBER INFORMATION

PRESCRIBER NAME:	NPI #:	MEDICAID ID#:
STATE LICENSE #:	SPECIALTY: ☐ NEUROLOGY OTHER:	PRACTICE NAME:
PRACTICE ADDRESS:		CITY:
STATE:	ZIP:	PHONE:	FAX:	OFFICE CONTACT NAME:
EMAIL:	PREFERRED COMMUNICATION: ☐ PHONE ☐ EMAIL ☐ FAX	

D MEDICAL & PRESCRIPTION INFORMATION

☐ G43.909 ☐ G43.009 ☐ G43.709 ☐ G43.719 ☐ R51 OTHER: ☐ NO KNOWN DRUG ALLERGIES

ALLERGIES:

ANTICONVULSANT/MIGRAINE MEDICATIONS CURRENTLY TAKING:	CONCURRENT MEDICATIONS:

ANTICONVULSANT/MIGRAINE MEDICATIONS PREVIOUSLY TRIED AND FAILED WITH REASON FOR DISCONTINUATION:

1. MEDICATION: REASON: DATE OF DISCONTINUATION:

2. MEDICATION: REASON: DATE OF DISCONTINUATION:

WEIGHT:	HEIGHT:	BMI:
TROKENDI XR ☐ 25 MG ☐ 50 MG ☐ 100 MG ☐ 200 MG	QUANTITY:	REFILLS:
DIRECTIONS:		

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.

PRECRIBER SIGNATURE:	DATE:

ORIGINAL SIGNATURE OF PRESCRIBER ☐ **DISPENSE AS WRITTEN** **INVALID WITHOUT DATE**

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NAME (FIRST, MIDDLE, LAST):	DOB:

E PATIENT ASSISTANCE PROGRAM APPLICATION

IS PATIENT LEGAL US RESIDENT: ☐ YES ☐ NO	HOUSEHOLD SIZE BASED ON IRS FORM 1040 OR 1040 EZ:
ADJUSTED GROSS INCOME AS IT APPEARS ON THE MOST RECENT YEAR'S FEDERAL TAX RETURN: $	YEAR:
HAVE YOU APPLIED FOR MEDICAID OR OTHER STATUTE-FUNDED PROGRAM(S)?: ☐ YES ☐ NO	APPROVED?: ◯ YES ◯ NO
IF NOT APPROVED FOR OTHER PROGRAMS, REASON FOR DENIAL:	

I understand that I am providing written instructions authorizing Supernus Pharmaceuticals and its vendor, under the Fair Credit Reporting Act ("FRCA"), to obtain information from my credit profile or other information from Experian Health, for the purpose of determining financial qualifications for programs administered by Supernus Pharmaceuticals. I certify that this information is complete and accurate to the best of my knowledge, and that I am unable to afford the medication requested. I understand that additional information may be requested to process this application, but that all medical and financial information will be kept confidential as required by law. I understand that the Product(s) made available to me under this program may be denied to me if I do not fully cooperate with efforts made to verify the information provided in this application, or if I do not take steps to secure alternative means of prescription coverage that are available to me, after I become aware of such alternatives. I certify that I shall not seek reimbursement for any medication dispensed as part of this program. I understand that completing this application form is not a guarantee of eligibility for the SupernusSupport Patient Assistance Program. I also understand that Supernus Pharmaceuticals may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare Part D plan, I cannot utilize my Part D plan benefits for products received through the SupernusSupport Patient Assistance Program for the duration of my enrollment. Any medication I receive through the SupernusSupport Patient Assistance Program will not count toward my true-out of pocket (TrOOP) expenses in Medicare Part D.

SIGNATURE:	DATE:	RELATIONSHIP TO PATIENT: ◯ SELF ◯ SPOUSE ◯ CHILD

F READ AND SIGN PATIENT AUTHORIZATION

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PATIENT SIGNATURE:	DATE:	RELATIONSHIP TO PATIENT: ◯ SELF ◯ SPOUSE ◯ CHILD