Osmolex ER™ (amantadine) *Extended-release Tablets*

Enrollment and Prescription Form

1-866-750-9516 1-833-OSMOLEX (1-833-676-6539)

1 Patient Information

First Name ______ MI ______ Last Name ______

Date of Birth ______ ☐ Male ☐ Female

Street Address ______

City ______ State ______ Zip ______

Primary Phone ______ Alternate Phone ______

2 Patient Insurance Information

Please attach a copy of the front and back of patient's prescription insurance card(s).

3 Physician Information

Physician Name ______ ☐ MD ☐ 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

Patient's Diagnosis Code ______

Has the Patient Tried Amantadine IR?

☐ Yes Date of last use ______ ☐ No

5 OSMOLEX ER Prescription Information

Patient Received Samples ☐ Yes ☐ No **Sample Dose and Days Supply** ______

One or both of the dose sections below must be completed. Please check the box above the section if the dose will not be utilized.

☐ Initial Dose Will Not Be Utilized

OSMOLEX ER Initial Dose

☐ 129 mg ☐ 193 mg ☐ 258 mg ☐ 322 mg

Directions ______

______

Quantity ______ Refills ___0___

☐ Maintenance Dose Will Not Be Utilized

OSMOLEX ER Maintenance Dose

☐ 129 mg ☐ 193 mg ☐ 258 mg ☐ 322 mg

Directions ______

______

Quantity ______ Refills ______

6 Prescriber Signature

I certify that the above therapy is medically necessary and that the information provided is accurate, to the best of my knowledge. I certify that I am the prescriber who has prescribed OSMOLEX ER to the above-named patient and that I provided the patient with the full Prescribing Information for OSMOLEX ER. I authorize Vertical Pharmaceuticals, LLC and its affiliates, agents, representatives, and service providers to: (1) forward this prescription to a dispensing pharmacy that will dispense the medication to the above-named patient; (2) process this AccessOsmolex™ program application ("Application") and verify the information contained in this Application; and (3) administer, analyze, and improve the AccessOsmolex™ program, which includes comprehensive patient support services, such as benefits investigation and related coverage and reimbursement services to allow us to help to ensure that the patient is able to appropriately access the drug that you have prescribed. I confirm that I have secured all necessary authorizations and consents so that I may share the patient's health information with Vertical Pharmaceuticals, LLC and its affiliates, agents, representatives, and service providers.

Prescriber Signature ______ Date ______

PM-US-OSM-0029

VERTICAL PHARMACEUTICALS, LLC