EPIDIOLEX® (cannabidiol) Patient Support Program

Start Form

Epidiolex engage™

☐ Requesting Prior Authorization Follow-up and Appeals Process Support

Complete all requested information below to help your patients get started on treatment. **All fields are required**, unless the information is being provided on an accompanying EMR face sheet (or the like). If submitting directly to a Specialty Pharmacy, the appropriate prescription, in accordance with state-specific requirements, must be submitted separately from this start form.

SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Height: _____ Weight: _____ kg

Current Medications: _____

Known Allergies: _____ ☐ No Known Allergies

Diagnosis:

The diagnosis designations below are intended to ensure communication of accurate information to your patient's insurance plan. **EPIDIOLEX is approved to treat seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex in patients 1 year of age and older.** See accompanying Prescribing Information.

ICD-10 Code: _____

Seizures associated with: ☐ Lennox-Gastaut syndrome ☐ Dravet syndrome ☐ Tuberous sclerosis complex

☐ Other (please specify): _____

If choosing "Other" and this medication is being prescribed for a use that is not listed on the FDA-approved label, by signing this patient start form and initialing here, I certify that the Prescriber has determined that EPIDIOLEX is medically necessary and appropriate for this patient and this patient's treatment will be supervised. **Healthcare Provider's Initials:** _____ **Date:** _____

Patient Address: _____ City/State/ZIP Code: _____

Group Home/Long-term Care Facility? ☐ Y ☐ N If yes, facility name and contact: _____

Full Name(s) of Legal Guardian(s): _____

Primary Phone: _____ ☐ Home ☐ Mobile ☐ Other Email: _____

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Other

SECTION 2: INSURANCE INFORMATION *(only required if submitting directly to a Specialty Pharmacy)*

Please provide a copy of the front and back of all prescription and medical benefit insurance cards.

Prescription Drug Insurance Provider: ☐ **Patient has no prescription drug coverage**

Insurer Name: _____ Insurer Phone: _____

Rx ID #: _____ Rx BIN: _____ Rx PCN: _____

Rx Group #: _____ Cardholder Name: _____ Date of Birth: _____

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Does the patient have other health insurance? ☐ Y ☐ N

Other Insurance Provider Name: _____

Policy ID #: _____ Group #: _____

Insurer Phone: _____ Cardholder Name: _____ Date of Birth: _____

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECTION 3: HEALTHCARE PROVIDER INFORMATION AND AUTHORIZATION

Prescriber Name: _____ Title: _____ Specialty: _____ DEA #: _____

NPI #: _____ State License #: _____ Tax ID #: _____ Medicaid Provider #: _____

Practice Name: _____ Office Contact Name: _____ Contact Phone: _____

Contact Fax: _____ Contact Email: _____

Preferred method of contact: Primary: ☐ Phone ☐ Fax ☐ Email Secondary: ☐ Phone ☐ Fax ☐ Email

Office Address: _____ City/State/ZIP Code: _____

As the undersigned Prescriber, or the Prescriber's Designated Agent, I hereby authorize the use or disclosure of the patient's health information contained on this start form to the patient's other healthcare providers (including pharmacies and Jazz Pharmaceuticals, Inc.), their respective agents and contractors and other designees that are involved in the patient's treatment ("Providers") and health plans or insurers and their respective agents and designees ("Insurers") to: (1) determine the patient's insurance benefits for EPIDIOLEX; (2) transmit the necessary information to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (3) contact the patient to obtain any necessary signatures, consents or information relating to the patient's treatment*; (4) contact the patient in order to ask whether the patient would like to apply for the Jazz Pharmaceuticals Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; and (5) to provide other related care coordination services.

I certify that the patient's authorization to use and disclose the patient's personally identifiable health information for the purposes permitted under this "Healthcare Provider Authorization" section has been obtained, as required by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Designated Agent, as applicable, for additional information as needed relating to the patient's EPIDIOLEX therapy. The undersigned certifies that: (1) the Prescriber has prescribed EPIDIOLEX for the identified patient; (2) the Prescriber has determined that EPIDIOLEX is medically necessary for this patient; (3) if the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.

Signature: _____ **Date:** _____ **Name/Title (if Designated Agent):** _____

*If legal guardian/patient is unavailable to provide a signature on Page 2, the Epidiolex Engage Team will contact the legal guardian/patient to obtain authorization.

Please fax the completed form, as well as the front and back of the patient's insurance cards, to one of the Epidiolex Engage Program providers below. If submitting directly to a Specialty Pharmacy, the appropriate prescription must also be submitted by fax or eRx.

Pharmacy	FAX	ADDRESS FOR eRx TRANSMISSION
AcariaHealth	1-877-541-1503	1311 West Sam Houston Pkwy, N #130 Houston, TX 77043
Accredo	1-888-302-1028	1640 Century Center Parkway Memphis, TN 38134
AllianceRx Walgreens Prime	1-877-231-8302	130 Enterprise Drive Pittsburgh, PA 15275
Amber Pharmacy	1-402-896-3774	10004 South 152nd Street Omaha, NE 68138
CVS Specialty	1-844-691-1343	800 Biermann Court, Suite B Mount Prospect, IL 60056
OR		
Epidiolex Engage™	1-855-518-7566	Prescription not required for submission to Epidiolex Engage

SECTION 4: HIPAA PATIENT AUTHORIZATION†

By signing this HIPAA Patient Authorization Form ("Authorization"), I hereby request and authorize my physicians, my pharmacists (including any specialty pharmacy that receives my prescription for EPIDIOLEX) and other healthcare providers ("Providers"), and my health insurers ("Insurers") and their respective agents and contractors, to disclose my protected health information, including but not limited to, information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and e-mail address(es), telephone number, date of birth and Social Security Number ("Protected Health Information" or "PHI"), to Jazz Pharmaceuticals, Inc. and its affiliates, and their respective agents and contractors (collectively, "Jazz Pharmaceuticals") for the following purposes: (i) to contact me, my personal representative(s), guardian(s) or designees, my Providers, Insurers or others I have identified, about my disease or treatment (including EPIDIOLEX); (ii) to provide me with information about support and patient assistance programs and services offered by Jazz Pharmaceuticals; and (iii) to improve or develop products (including EPIDIOLEX), services, programs, or treatment related to my disease; (iv) to de-identify my PHI or combine it with other data for research or analysis. I understand that my pharmacy provider may receive remuneration from Jazz Pharmaceuticals in exchange for sharing information or for my pharmacy providing any support services to me.

I understand that once my PHI has been disclosed to Jazz Pharmaceuticals, my information may be protected by certain state privacy laws but may no longer be protected under federal privacy laws and that my PHI may be subject to re-disclosure. I understand that Jazz Pharmaceuticals will not sell my name, address, e-mail address, or any other information to another party for their own marketing use. I understand that I am not required to agree to this Authorization. If I do not agree, my treatment (including receipt of EPIDIOLEX), payment for my treatment, or eligibility for insurance benefits will not be affected, but I may not receive the other services described above.

I understand that I may cancel this Authorization at any time by: faxing my cancellation to 1-855-518-7566, calling 1-833-GBNGAGE (1-833-426-4243) or mailing a letter to PO Box 5490, Louisville, KY 40255. The Jazz Pharmaceuticals representative shall provide timely notification of my cancellation to the applicable parties. Once they receive and process the notice of cancellation of this Authorization, the applicable parties may no longer share my PHI with Jazz Pharmaceuticals as permitted by this Authorization. However, cancelling this Authorization will not affect any action(s) taken by applicable parties based on this Authorization before receipt of my notice of cancellation. This Authorization will expire in five (5) years from the date this Authorization is signed below, unless a shorter period is required by law of my state of residence. I understand that I have a right to request and to receive a copy of this Authorization.

By signing below, I am indicating that I have read and understood the information set forth in this Authorization.

Patient Name:_____ Date of Birth: _____

Name (if Different from Patient): _____ Relationship to Patient:_____

Email:_____ Phone: _____

Signature of Patient or Legal Guardian, if Applicable: _____ Date: _____

†HIPAA Patient Authorization is also available in Spanish at: www.EPIDIOLEXhcp.com/HIPAASpanish.

For additional assistance, call us at 1-833-GBNGAGE (1-833-426-4243). Please see full Prescribing Information.