ONAPGO™ (APOMORPHINE HCl) PRESCRIPTION FORM FOR VA PATIENTS

Forward the completed form to the VA pharmacy. The VA pharmacy will review and fax the document to CVS Specialty at 1-844-691-1345.

ONAPGO™ (apomorphine HCl) injection, for subcutaneous use • 4.9 mg/mL

1. PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Other Phone: _____

Patient Email: _____

Alternate Contact Name: _____

Relationship to Patient: _____

Cell Phone: _____ Other Phone: _____

Alternate Contact Email: _____

Preferred Patient Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Patient Contact Method: ☐ Phone ☐ Text ☐ Email

2. VA PHARMACY INFORMATION

Name of VA Facility: _____ DEA #: _____

Address: _____ Suite: _____ City: _____ State: _____ ZIP: _____

Primary Purchasing Contact Name: _____ Telephone: _____ Fax: _____ Email: _____

Primary Clinical Contact Name: _____ Telephone: _____ Fax: _____ Email: _____

Secondary Purchasing Contact Name: _____ Telephone: _____ Fax: _____ Email: _____

Secondary Clinical Contact Name: _____ Telephone: _____ Fax: _____ Email: _____

Payment Method: ☐ Credit Card (call pharmacy contact) ☐ E-invoice Tungsten Network Ship to: ☐ Patient ☐ VA Pharmacy

Purchase Order #*: _____ **If a purchase order is not included, CVS will email the purchasing contacts to request the PO and confirm the purchase price.*

3. PRESCRIBER INFORMATION

Prescriber Name (First, MI, Last): _____ NPI #: _____

Facility Name: _____ Office Contact: _____

Office Phone: _____ Office Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

4. ONAPGO PRESCRIPTION INFORMATION

Confirm Diagnosis: ☐ **ICD-10: G20.A2** Parkinson's disease without dyskinesia, with fluctuations ☐ **ICD-10: G20.B2** Parkinson's disease with dyskinesia, with fluctuations ☐ **Other:** _____

FILL OUT ALL SECTIONS BELOW – A, B, C, & D

A

Required for all new patients

☐ **ONAPGO Infusion Device & Kit (1)**

Provided to patient at start, programmed by HCP and/or Circle of Care Clinical Nurse Navigator

If replacement needed:

☐ **Replacement Infusion Device & Kit (1)**

As determined by manufacturer

B **Continuous Dose Prescription**

Under medical supervision, infuse subcutaneously

Lowest continuous dosage is 1.0 mg/hr

Max continuous dosage 6.0 mg/hr

Max recommended daily dose, including extra doses, is 98 mg (1 cartridge per day)

Select one: ☐ 16 hours or less *or* ☐ _____ hours

Continuous dosage: ☐ 1.0 mg/hr *or* ☐ _____ mg/hr

Titrate continuous dosage by: ☐ 0.5 mg/hr *or* ☐ 1 mg/hr

INSTRUCTIONS: *Titrate every 1–7 days to therapeutic effect & tolerability*

C **Extra Dose(s) Per Day – Select one:**

☐ None ☐ 1 extra dose ☐ 2 extra doses ☐ 3 extra doses

Hold initiating/programming extra dose until continuous dosage is optimized ☐ Yes ☐ No

If extra dose selected, complete below

Extra dose: ☐ 0.5 mg or ☐ 1 mg *or* ☐ _____ mg

Titrate extra dose by: ☐ 0.5 mg *or* ☐ 1 mg

INSTRUCTIONS:

Max recommended extra dose is 2 mg per extra dose

No more than 3 extra doses per day over 16 hours with at least 3 hours between extra doses. If 3 extra doses are routinely required consider further adjustment of the continuous dosage.

Titrate every 1–7 days to therapeutic effect & tolerability

D **Dispense Quantity: 30 Cartridges** *(1 cartridge per day)* **Refills:** ☐ 11 refills or ☐ _____ refills

Cost of medication is not inclusive of the ONAPGO device and ancillary supplies. Supplies listed below are standard for a 30-day prescription: Thirty (30) ONAPGO cartridge holders | One (1) gallon sharps container | Four (4) boxes of Infusion Sets *[proximal female luer lock connector, line 42" or less, 90-degree cannula insertion angle, and subcutaneous needle with no more than 9 mm insertion depth]* | Two hundred (200) alcohol swabs.

Titration Orders: *Continuous and extra dose titration procedures, per full Prescribing Information, under medical supervision. Titrate by dose increments prescribed above, as directed by prescriber, at start, every few days and as needed per patient response until patient reaches therapeutic effect or max continuous dosage of 6 mg/hr or 98 mg/day.*

SIGN HERE

Prescriber Signature and Date — No Stamps

OR

Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Date:**

May Substitute / Product Selection Permitted / Substitution Permissible **Date:**

IMPORTANT: If complementary in-home Start and Titration support/education by the Supernus® Circle of Care™ Clinical Nurse Navigator is requested by the patient, a copy of this prescription form must also be faxed to the Supernus HUB at 1-888-525-2431.

I certify that the information in this ONAPGO Prescription Form is accurate to the best of my knowledge and that I prescribed ONAPGO based on medical necessity. I confirm that I obtained my patient's authorization, in compliance with applicable laws, to share their health information with Supernus Pharmaceuticals and the Circle of Care™ program for education and support. I agree to provide additional information if requested and authorize the program to transmit the prescription to the pharmacy.

Supernus® Pharmaceuticals

Forward completed form to the VA Pharmacy.