PRESCRIPTION AND ENROLLMENT FORM

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

GETTING YOUR PATIENTS STARTED ON ONAPGO™

1 PATIENT AUTHORIZATION FORM

After discussing ONAPGO, have your patient read and sign the Patient Authorization Form on page **1**.

By signing this form, your patient is electing to enroll in the ONAPGO Circle of Care™ program, which includes HUB Coordinators and Clinical Nurse Navigators.

Provide your patient with page **4** for their records.

2 COMPLETE THE PRESCRIPTION FORM

Complete and sign pages **2** and **3**. Incomplete forms will delay access.

3 FAX COMPLETED AND SIGNED PAGES

Fax the completed and signed pages to **1-888-525-2431**.

- Page **1**—Signed Patient Authorization Form
- Pages **2** and **3**—Completed and signed Prescription and Enrollment Form

INCOMPLETE FORMS WILL DELAY ACCESS TO ONAPGO SERVICES.

KEY AREAS TO COMPLETE

Patient Authorization Form

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

FAX this page

PRESCRIPTION AND ENROLLMENT FORM

Complete and Fax: 1-888-525-2431 | Phone: 1-833-3ONAPGO (1-833-366-2746)

Patient Name:	**DOB:**

Please read the following carefully, then sign and date below.

I. Patient Authorization for Release of Health Information Form

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") and each of their respective representatives, employees, and agents (collectively "Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Protected Health Information" or "PHI") to Supernus Pharmaceuticals and its agents, contractors, and other partners, including companies working with Supernus, which may be branded as Circle of Care™ (collectively, "Supernus") for Supernus to (i) provide me with support and related information and materials on any of Supernus' products, including, but not limited to, educational support provided in-person, online or by telephone, financial assistance, and medication adherence support ("Programs"), (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the Programs provided, and (iii) provide me with information about Supernus' products, services, and programs and other topics of interest for marketing, educational or other purposes.

I understand I have the option and agree to having Supernus perform, on my behalf, an electronic benefit verification and soft credit check under the Fair Credit Reporting Act "FCRA" for the purpose of determining financial eligibility for Patient Assistance Program "PAP" for the provision of free medication, if applicable and I qualify. Additionally, if free medication is provided via PAP or a Bridge Program, I will not seek reimbursement from my insurance plan.

For purposes of clarification, Supernus includes but is not limited to brand specific support through a hub service provider, specialty pharmacy service providers, Circle of Care Clinical Nurse Navigators, as well as other entities under contract with Supernus to support these or similar aspects of the Programs. For purposes of providing support through the Programs, I thereby authorize Supernus to contact me via text messaging, phone, fax, and/or mail – including texts and calls made using an automatic telephone dialing system or prerecorded or artificial voice messages – and to leave a detailed message that includes reference to ONAPGO treatment, as needed.

Once my PHI has been disclosed to Supernus, I understand that state and federal privacy laws no longer protect the information. However, Supernus agrees to protect my PHI by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Supernus in exchange for the PHI and/or for any support services provided to me.

I understand that I am not required to sign this Authorization and that my Providers will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. This Authorization will expire in 10 years or a shorter period if required by state law, unless I revoke it sooner by writing Circle of Care/Supernus, c/o PharmaCord, PO Box 5490, Louisville, KY 40255. I understand that revoking my Authorization will not affect any use of my information that occurred before my request was processed. I am entitled to a copy of this signed authorization. I certify the information provided on this form is complete and accurate, to the best of my knowledge and I understand that Supernus can revise, change or terminate the Programs at any time.

I have read and understand the Patient Authorization for Release of Health Information Form and agree to the terms.
A signature is required in order to receive Supernus services.

SIGN HERE ***Signature or "Verbal Consent"*** _____ ***Date of Consent*** _____

Signature of Patient **Date**

In addition, I authorize the disclosure of my Protected Health Information to the following designated individual(s) (optional):

_____ _____

Designated Individual (print name) **Relationship**

II. Marketing/Other Communications Opt-In (optional)

I further authorize Supernus, and companies working with Supernus, any of which may be branded as Circle of Care (collectively "Supernus"), to contact me by mail, email, fax, telephone call, and text message for marketing purposes or otherwise provide me with information about Supernus' products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. I understand and agree that any information that I provide may be used by Supernus to help develop new products, services, and programs. Note that Supernus will not sell or transfer my personal data to any unrelated third party for marketing purposes without my express permission.

I have read and understand the Marketing/Other Communications Opt-In and agree to the terms.

Signature of Patient: _____ **Date:** _____

Designated Individual (print name): _____ **Relationship:** _____

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Fax pages 1, 2, and 3 to 1-888-525-2431. Please provide page 4, Patient Authorization and Important Safety Information, to the patient.

Please retain a copy of the form for your own records.
Additionally, please provide page 4 to your patient.

Clearly print patient name and DOB.

IMPORTANT: Have your patient read and sign Section I of the Patient Authorization Form.

If patient is not in the office to sign and verbal consent has been provided, please indicate by writing "Verbal Consent" and the date of consent.

If patient has a designated care partner, their name, relationship, and phone number can be added.

To participate in further Circle of Care support services and communications, please ensure patient signs and provides designated care partner, if applicable.

FAX COMPLETED PATIENT AUTHORIZATION FORM TO 1-888-525-2431 WITH A COPY OF THE PRESCRIPTION AND ENROLLMENT FORM.

KEY AREAS TO COMPLETE

Page 2

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

FAX this page

PRESCRIPTION AND ENROLLMENT FORM

Complete and Fax: 1-888-525-2431 | Phone: 1-833-3ONAPGO (1-833-366-2746)

1. PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Address: _____
City: _____ State: _____ ZIP: _____
Cell Phone: _____ Other Phone: _____
Patient Email: _____
Preferred Patient Language: ☐ English ☐ Spanish ☐ Other: _____
Preferred Patient Contact Method: ☐ Phone ☐ Text ☐ Email

Alternate Contact Name: _____
Relationship to Patient: _____
Cell Phone: _____ Other Phone: _____
Alternate Contact Email: _____

2. INSURANCE INFORMATION *Please fax a copy of all insurance cards, front and back (prescription and medical insurance)*

Primary Medical Insurance: _____
ID #: _____
Phone #: _____

Prescription Insurance: _____
BIN: _____ PCN: _____ Group #: _____
Phone #: _____

3. PRESCRIBER INFORMATION

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

Medicare PTAN: _____
Office Contact: _____
Office Fax: _____
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 and insurance eligibility

B **Continuous Dosage Prescription**
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

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)
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

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:**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words **"No Substitution"** _____
ATTN: New York and Iowa providers, please submit electronic prescription

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 understand that completing this form does not guarantee assistance. 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 benefits eligibility, coverage, and support. I agree to provide additional information if requested and authorize the program to transmit the prescription to the pharmacy. I will not seek reimbursement for any free product from federal or third-party insurers and will only provide the medication to the patient at no cost. I understand that Supernus products and support are complimentary, with no obligation to prescribe, purchase, or recommend them.

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Prescribers must sign for the Prescription above & for the Circle of Care Clinical Nurse Navigator Services on page 3 and fax pages 1, 2, and 3 to 1-888-525-2431.

Include copies of both sides of **ALL** insurance cards.

Please provide the PTAN (Provider Transaction Access Number)—your unique Medicare identification # (usually 6 digits) that was assigned when your Medicare enrollment was approved. To participate in Medicare, a provider needs both an NPI and a PTAN #.

IMPORTANT: Make sure ALL areas within sections A, B, C, and D are completed.

Select "Replacement Infusion Device & Kit" to allow the Specialty Pharmacy to replace the ONAPGO device in case of an accident or breakage.

For **New Patients**, the recommended starting continuous dosage is 1.0 mg/hr.

Ensure you select a continuous dosage titration increment.

Extra dose is a bolus dose on top of the continuous dosage. Select the # of extra doses and titration increments. You can select to hold the extra dose until the continuous dosage is optimized.

Sign Dispense as Written (DAW) for ONAPGO and Circle of Care services. Please sign and date on 1 line only.

FAX BOTH PAGES OF THE COMPLETED PRESCRIPTION AND ENROLLMENT FORM TO 1-888-525-2431 WITH A COPY OF THE PATIENT AUTHORIZATION FORM.

KEY AREAS TO COMPLETE

Page 3

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

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Complete and Fax: 1-888-525-2431 | Phone: 1-833-3ONAPGO (1-833-366-2746)

Patient Name:

5. Circle of Care™ Clinical Nurse Navigator Support – Patient will be enrolled in the program as described below:

- **Initial Patient Support and Education:** Clinical Nurse Navigator schedules and provides education to patient on ONAPGO. Clinical Nurse Navigator will review expectations, work to establish proficiency with the ONAPGO device, review Patient Instructions for Use including daily administration and setup, and train and educate on skin health. The patient will be educated to use ONAPGO per the prescribers' orders. Education may be conducted in person, by phone and/or by video call.
- **Start (Initiation) Support for Patients:** Clinical Nurse Navigator schedules and coordinates ONAPGO start appointment with patient. During start appointment, the patient will be instructed and trained on administering ONAPGO consistent with the prescribers' orders. The Clinical Nurse Navigator will record the patient's response to ONAPGO. In addition, the Clinical Nurse Navigator will educate on skin health, future dose titration and optimization, and daily administration. Start (Initiation) services may be conducted in-home or in-office as indicated by the prescriber.
- **Dose Titration Orders:** Clinical Nurse Navigator schedules and coordinates ONAPGO titration visits consistent with the prescribers' orders. Titration visits will occur in the patient's home and the ONAPGO continuous dosage and extra dose will be titrated per sections **B and C** on the prescription form. Titration will continue until an optimal dose has been reached. The device settings will be set by the prescriber and/or a Supernus/MDD US Operations Clinical Nurse Navigator based on sections **B and C** on the prescription form.
- **Ongoing Support and Education:** Clinical Nurse Navigator will continue to educate on device proficiency, skin health, and daily administration and setup for the patient's entire time on ONAPGO. Clinical Nurse Navigator will also continue to educate on dose optimization, as needed, for the patient's entire time on ONAPGO. **Clinical Nurse Navigators do not give medical advice about a patient's personal treatment plan and will refer patients to their healthcare provider for that specific medical advice.**

Start (Initiation) Visit will occur: ☐ **Home** ☐ **Office** ☐ **Facility** (e.g., ALF, SNF) ☐ **Other:**_____

Dose Titration Visits will occur: ☐ **Home** ☐ **Office** ☐ **Hybrid** (In-home and office)

Prescriber Preferred Phone Contact Method for Start and Titration: _____ ☐ **Cell** ☐ **Office**

Optional – Clinical Nurse Navigator Support Opt-Out:

By checking any of the boxes below, you are opting your patient out of full Clinical Nurse Navigator Support

☐ **No**, my staff will **conduct the Start (Initiation),** but a Clinical Nurse Navigator may be used for Dose Titration Orders, Initial, and Ongoing Support and Education.

☐ **No**, my staff will **conduct the Start (Initiation) and Dose Titration**, but a Clinical Nurse Navigator may be used for Initial and Ongoing Support and Education.

☐ **No**, my staff will **conduct the Start (Initiation) and Dose Titration, as well as Initial and Ongoing Support and Education.**

SIGN HERE

Prescriber Signature **Date**

Prescriber Declaration: I certify that (a) any support provided through the Circle of Care program on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use ONAPGO or any other Supernus product or service for anyone, (b) my decision to prescribe ONAPGO was based on my determination of medical necessity as set forth herein, (c) all Clinical Nurse Navigator services are intended to go to the full benefit of the patient, and (d) I will provide appropriate medical care consistent with my professional duties and independent medical judgment. I acknowledge that I cannot bill for activities provided by the Circle of Care program.

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Prescribers must sign above for the Circle of Care Clinical Nurse Navigator Services and fax along with the signed Prescription Form (page 2) and signed Patient Authorization (page 1) to 1-888-525-2431.

Clearly print patient name.

NOTE: The Clinical Nurse Navigator will provide in-home education and support to your patient throughout their entire time on ONAPGO.

Specify ONAPGO Start Visit location.

Specify where ONAPGO Dose Titration Visits will occur—**hybrid** will allow flexibility between in-office and in-home as you see fit.

Specify how you would prefer to be contacted by the Clinical Nurse Navigator.

Signature and date are **REQUIRED** for Clinical Nurse Navigator Services.

FAX BOTH PAGES OF THE COMPLETED PRESCRIPTION AND ENROLLMENT FORM TO 1-888-525-2431 WITH A COPY OF THE PATIENT AUTHORIZATION FORM.

PLEASE PROVIDE PATIENT WITH A COPY OF THE AUTHORIZATION AND CONSENT FORM

Patient Copy

I. Patient Authorization for Release of Health Information Form

By signing this Authorization, I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") and each of their respective representatives, employees, and agents (collectively "Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Protected Health Information" or "PHI") to Supernus Pharmaceuticals and its agents, contractors, and other partners, including companies working with Supernus, which may be branded as Circle of Care™ (collectively, "Supernus") for Supernus to (i) provide me with support and related information and materials on any of Supernus' products, including, but not limited to, educational support provided in- person, online or by telephone, financial assistance, and medication adherence support ("Programs"), (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the Programs provided, and (iii) provide me with information about Supernus' products, services, and programs and other topics of interest for marketing, educational or other purposes.

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I have read and understand the Marketing/Other Communications Opt-In and agree to the terms.

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This page should be provided to the patient.

FRONT

USE

ONAPGO is a prescription medicine used to treat motor fluctuations (OFF episodes) in adults with advanced Parkinson's disease (PD). It is not known if ONAPGO is safe and effective in children.

IMPORTANT SAFETY INFORMATION

Do not take ONAPGO if you are:

- taking certain medicines to treat nausea (ondansetron, granisetron, dolasetron, palonosetron) and alosetron. People taking ondansetron with apomorphine had very low blood pressure and lost consciousness (blacked out).
- allergic to apomorphine or to any ingredients in ONAPGO including sulfite. Sulfites can cause severe, life-threatening allergic reactions, especially in people with asthma.

Call your healthcare provider or get emergency help right away if you have any of the following symptoms of severe life-threatening allergic reaction:

• hives • itching • rash • swelling (eyes, tongue, lips, or mouth) • chest pain • throat tightness • trouble breathing or swallowing.

Before you start using ONAPGO, tell your healthcare provider about all of your medical conditions, including:

• difficulty staying awake during the daytime • dizziness, fainting spells, or low blood pressure • asthma • allergies to any medicines containing sulfites • heart problems • a history of stroke or other brain problems • kidney problems • liver problems • a mental problem called a major psychotic disorder • drinking alcohol • if you are pregnant or plan to become pregnant, or breastfeeding or plan to breastfeed. It is not known if ONAPGO will harm your unborn baby or pass into your breast milk.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription (over-the-counter) medicines, vitamins, and herbal supplements. ONAPGO and certain other medicines may affect each other and cause serious side effects.

- If you take nitroglycerin under your tongue (sublingual) while using ONAPGO, your blood pressure may decrease and cause dizziness. If possible, lie down before taking it and then try to continue lying down for at least 45 minutes after.

What should I avoid while using ONAPGO?

- **Do not** drink alcohol. It can increase your chance of developing serious side effects.
- **Do not** take medicines that make you sleepy.
- **Do not** drive, operate machinery, or do other dangerous activities until you know how ONAPGO affects you.
- **Do not** change your position too fast, get up slowly from sitting or lying. ONAPGO can lower blood pressure and cause dizziness or fainting.

What are the possible side effects of ONAPGO?

ONAPGO may cause serious side effects, including:

- **blood clots**. Infusing ONAPGO into a vein (intravenous) can cause blood clots. **Do not** infuse ONAPGO in your vein.
- **nausea and vomiting are common**. May be serious or severe. Your healthcare provider may prescribe medicine (trimethobenzamide) to help decrease nausea/vomiting. Follow your healthcare provider's instructions on how to take/when to stop this medicine.
- **sleepiness or falling asleep during the day is common and may be serious**. Some people may get sleepy during the day or fall asleep without warning while doing everyday activities such as talking, eating, or driving.
- **dizziness is common and may be serious**. ONAPGO can lower your blood pressure and cause dizziness. Dizziness can happen when treatment is started or when the dose is increased. **Do not** get up too fast from sitting or lying down, especially if you have been sitting or lying down for a long time.
- **falls**. Changes that can happen with PD, and effects of some PD medicines, including ONAPGO, as well as trimethobenzamide, can increase your risk of falling.
- **infusion site reaction is common and may be serious**. Reactions and infections including infusion site nodules, redness, bruising, swelling, rash, and itching may happen.
- **hallucinations or psychotic-like behavior**. ONAPGO can cause/worsen psychotic-like behavior including hallucinations (seeing or hearing things that are not real), confusion, excessive suspicion, aggressive behavior, agitation, delusional beliefs (believing things that are not real), and disorganized thinking.
- **sudden uncontrolled movements (dyskinesia) are common and may be serious**. Some people with PD may get sudden, uncontrolled movements after treatment with some PD medicines. ONAPGO can cause/make dyskinesia worse.
- **low red blood cells (hemolytic anemia)**. Tell your healthcare provider if you have: become pale, fast heartbeat, feel more tired or weaker than usual, skin or eyes look yellow, chest pain, shortness of breath or trouble breathing, dark-colored urine, fever, dizziness, or confusion.
- **strong (intense) urges**. New or increased gambling urges, sexual urges, and other intense urges have been reported.
- **heart problems**. If you have shortness of breath, fast heartbeat, or chest pain, call your healthcare provider or get emergency help right away.
- **serious heart rhythm changes (QT prolongation)**. Tell your healthcare provider right away if you have a change in your heartbeat (a fast or irregular heartbeat), or faint.
- **allergic reaction**. Tell your healthcare provider or get medical help right away if you get hives, itching, rash, swelling of the eyes and tongue, or trouble breathing.
- **tissue changes (fibrotic complications)**. Some people have had changes in the tissues of their pelvis, lungs, and heart valves when taking medicines called non-ergot derived dopamine agonists like ONAPGO.
- **prolonged painful erections (priapism)**. May occur. If you have an erection that lasts more than 4 hours, call your healthcare provider or go to the nearest hospital emergency room right away.

Other common side effects of ONAPGO include headache and trouble falling asleep or staying asleep (insomnia).

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Patients and care partners must receive complete instructions on the proper use of ONAPGO. Please see Patient Information and talk to your healthcare provider.

This page should be provided to the patient.

BACK