WELCOME TO THE AMNEAL CREXONT® (CARBIDOPA AND LEVODOPA EXTENDED RELEASE ASSISTANCE PROGRAM

SECTION 1 - PATIENT INFORMATION: (REQUIRED-PLEASE PRINT CLEARLY)

NOTE: UPON APPROVAL, MEDICATION WILL BE SHIPPED TO THE PATIENT'S ADDRESS

Last Name, First Name:

Street Address/Shipping Address: (No PO Boxes)

City/State/Zip Code:

Patient Email Address:

Gender:

Patient Date of Birth:
/ /

Phone Number:
( )

U.S. Resident:
☐ Yes ☐ No

Medicare Number or SSN:

Number of people in household (include self):
1 2 3 4 5 6 7

SECTION 2 - PATIENT INSURANCE INFORMATION (REQUIRED)

Do you have a State Patient Assistance Program? ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No

Do you have Medicare A? ☐ Yes ☐ No

Do you have Medicare B? ☐ Yes ☐ No

Do you have Medicare D? ☐ Yes ☐ No

(If yes, please attach current years proof of Out-of-Pocket Prescription costs)

Do you have prescription drug coverage? ☐ Yes ☐ No

(If yes, please attach a copy of your insurance card front and back.)

Plan Name:

Phone Number:

Group Number:

Policy Number:

BIN:

SECTION 3 - PATIENT AUTHORIZATION FOR USE AND DISCLOSURE (REQUIRED)

By signing below, I authorize my healthcare provider(s) and health insurer(s) to disclose personal health information about me related to my treatment or potential treatment with CREXONT® (carbidopa and levodopa) Extended Release Capsules ("My Information") Amneal Pharmaceuticals LLC's patient assistance program service providers and authorized agents (collectively, the "Assistance Group") for purposes of my enrollment and participation in the Amneal Patient Assistance Program (the "Program") and for such additional uses and to disclose My Information to my healthcare provider(s) and health insurer(s), and to the Centers for Medicare and Medicaid Services ("CMS"), as deemed necessary to verify the accuracy and completeness of this Program application, and to administer and provide services available through the Program. I understand that when My Information is disclosed to the Assistance Group, it may be subject to re- disclosure and no longer protected by federal privacy, law, but that the Assistance Group intends to use and disclose My Information only as described in this Authorization.

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I understand that I may decline to sign this form and that will not affect the way my health care providers or insurer(s) will provide me with their respective services, although I will then be ineligible to participate in the Program. I also understand that I may cancel this Authorization at any time by sending a notice of cancellation to the Assistance by calling 855-459-9909. If I do not cancel the Authorization, it will remain valid for the duration of the period I am enrolled in the Program, or such lesser period as may be required by applicable state law.

MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4) this authorization expires ONE YEAR from the date of signature.

I am entitled to receive a copy of this Authorization once it is signed below.

Name of Patient	Signature	Date
Name of Legal Representative	Signature	Date

If signed by representative, state relationship to patient: _____

☐ Text me about Amneal Patient Assistance Program information. By checking this box, I consent to receive text messages after enrollment into the Amneal Patient Assistance Program. For each program service, I will receive a welcome text asking me to reply CONFIRM to opt-in. Message and data rates may apply; the number of messages varies based on program use but is up to 10 texts per month. Reply STOP to cancel. Privacy policy and full Terms are available at https://amneal.com/internet-privacy-policy/ and https://amneal.com/about/responsibility/patient-assistance-programs/smstc. If this box is NOT checked, you will NOT receive text messages from the Amneal Patient Assistance Program.

PATIENT INFORMED CONSENT TO TERMS AND CONDITIONS OF PATIENT ASSISTANCE PROGRAM

I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Amneal Patient Assistance Program ("Program") if I obtain coverage through another source or if I no longer meet the income criteria for the Program.

I understand that I am providing written instructions to the Program Administrator under the Fair Credit Reporting Act authorizing the Program Administrator to obtain information from my credit profile or other information from Experian Health. I give consent to the Program Administrator to obtain such information solely to determine if my income meets eligibility standards to receive free medication from the program.

I understand that completing this form does not ensure that I will qualify for the Program. I understand that Amneal Pharmaceuticals LLC reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program.

Name of Patient	Signature	Date
Name of legal representative	Signature	Date

SECTION 4 – CREXONT® ASSISTANCE PROGRAM PRESCRIPTION INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Medication and Strength:

- CREXONT® 35/140mg
- CREXONT® 52.2/210 mg
- CREXONT® 70/280 mg
- CREXONT® 87.5/350mg

Directions:_____

Quantity:_____ Refills:_____

Check the box if you would like to opt into Bridge Program:
☐ One month bridge supply

Diagnosis ICD-10
☐ G20 Parkinson's Disease

- G21.2 Secondary Parkinson's due to other external agents
- G21.3 Postencephalitic parkinsonism

☐ Other _____

Other Current Medications (if applicable):_____

Known Drug Allergies (if applicable):_____

Patient Weight:_____ Patient Height:_____

SECTION 5 - PRACTITIONER INFORMATION AND ATTESTATION: (PLEASE PRINT CLEARLY)

Prescriber Last Name,First Name _____ Office Contact Person _____

Prescriber State License # _____ Prescriber Phone Number _____

Prescriber NPI _____ Prescriber Fax Number _____

Prescriber Address _____

_____

Collaborative Prescriber (Printed) _____

Collaborative Prescriber NPI _____

*If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form, submit via E-script or verbally to the pharmacy pursuant to NY or NJ state laws.

By signing below, I verify that the information provided in this enrollment form is complete and accurate to the best of my knowledge. I understand that Amneal Pharmaceuticals LLC reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through Amneal Patient Assistance Program. Finally, I authorize Amneal Pharmaceuticals LLC, its affiliates, representatives and agents to forward the above prescription, by fax or other mode of delivery, to a pharmacy for fulfillment.

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Prescriber Signature _____ Date of Signature _____