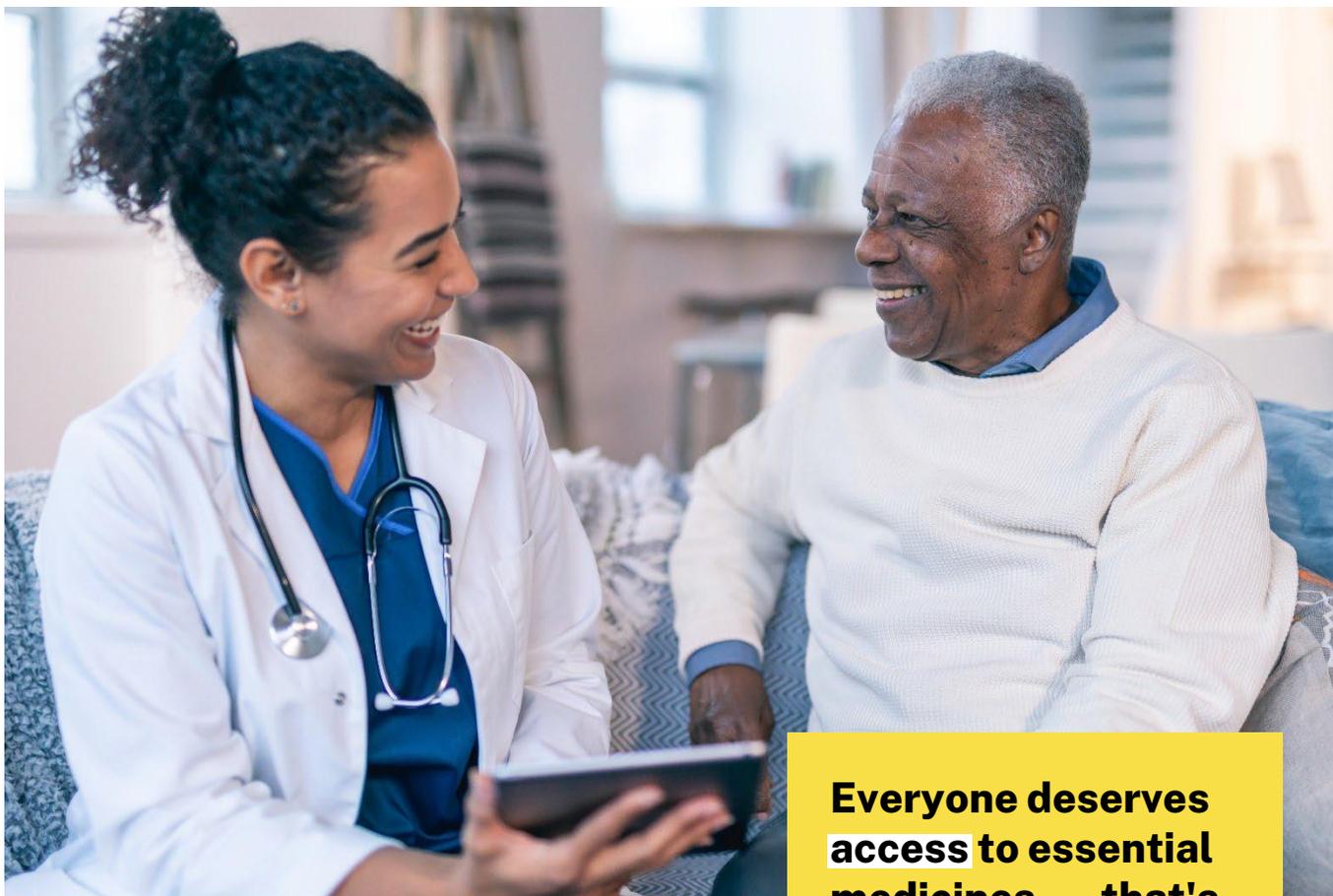


# THE AMNEAL PATIENT SUPPORT SERVICES PROGRAM



**Everyone deserves  
access to essential  
medicines — that's  
why we're here**

*Amneal*

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# PATIENT SUPPORT SERVICES PROGRAM OVERVIEW

## The Amneal Patient Support Services Patient Assistance Program

Eligible patients have the opportunity to apply to receive Patient Assistance for free medication for up to one year of ONGENTYS® (opicapone) capsules.

For Patient Assistance consideration, please complete the Patient Assistance prescription in Section 4. Patients must satisfy financial and other program requirements.

## The Amneal Patient Support Services One-time 30-Day Complimentary Supply

Patients may also be eligible to receive a **One-time 30-Day Complimentary Supply** of ONGENTYS® to start their therapy. To be considered eligible for a one-time 30-Day Supply of ONGENTYS®, please complete the One-time 30-Day Complimentary Supply prescription in Section 5.

## Patient Assistance Program and one-time 30-Day Complimentary Supply

You may also elect to enroll your patient in Patient Assistance and a **one-time 30-Day Complimentary Supply**. For consideration of a one-time 30-day complimentary supply of ONGENTYS® and for free medication for up to one year of ONGENTYS® please complete Sections 4 and 5.

This form serves as an application for **Patient Assistance**, a **one-time 30-Day Complimentary Supply**, or **both Patient Assistance and a one-time 30-Day Complimentary Supply**.

ONGENTYS® (opicapone) capsules are available by prescription only.

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## PATIENT SUPPORT SERVICES PROGRAM INSTRUCTIONS

Thank you for your interest in the Amneal Patient Support Services Program. This program is for ONGENTYS® (opicapone) capsules, as listed below. Attached is a copy of the application form.

## APPLICATION INSTRUCTIONS FOR PATIENTS - REQUIRED

- Complete all 3 of the following sections:
  - Patient Information (Section 1)
  - Insurance Information (Section 2)
  - Patient Authorization (Section 3)
- Sign the application

## APPLICATION INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

- Have patient complete the Patient Information sections 1, 2, and 3 and sign the application.
- Complete applicable Prescription Information in section 4 and/or section 5.
- Complete Clinical Information in section 6 and Practitioner Information in section 7. Provide phone, fax, State License number or NPI.
- Fax or mail the application to:

**Amneal Patient Support Services Program**  
**PO Box 362**  
**Columbus, OH 43216**  
**Phone 1-855-459-9909 Fax 1-614-455-0883**

If the Patient Assistance Program is approved, patients are eligible to receive free medication for up to one year. Medications will be shipped to the patient's home. The Amneal Patient Support Services Program will send an application for renewal when a patient's enrollment is due to expire.

**Please call 1-855-459-9909 for questions regarding this program or application.**  
Monday through Friday, 8:00 am to 8:00 pm EST, excluding holidays

## THE FOLLOWING MEDICATION ARE AVAILABLE THROUGH THE AMNEAL PATIENT SUPPORT SERVICES PROGRAM

ONGENTYS 25 mg\*  
ONGENTYS 50 mg\*

\*If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form. ONGENTYS® (opicapone) capsules in the following strengths 25 mg, 50 mg, (available in a 30-, 60- or 90-day supply)

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## SECTION 1 - WELCOME TO THE AMNEAL PATIENT SUPPORT SERVICES FOR ONGENTYS (opicapone) capsules

PATIENT INFORMATION: (REQUIRED-PLEASE PRINT CLEARLY)

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

This enrollment form may be used to enroll your patient in PAP, one-time 30-Day Complimentary Supply, or PAP and a one-time 30-Day Complimentary Supply. Please be sure to select the appropriate service in the Prescription Information section.

Last Name, First Name: _____	Gender**: _____	Patient Date of Birth: / / _____
Street Address/Shipping Address: (No PO Boxes) _____	Phone Number: ( ) _____	U.S. Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State/Zip Code: _____	Medicare Number or SSN: _____	
Patient Email Address: _____	Number of people in household (include self): 1      2      3      4      5      6      7	

\*\*Gender is defined as sex at birth

## SECTION 2-PATIENT INSURANCE INFORMATION (REQUIRED) –

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE FRONT AND BACK COPY OF INSURANCE CARD FOR EACH TYPE OF INSURANCE CARD FOR EACH TYPE OF INSURANCE

Patient Has No Insurance

Patient Has Insurance

### Primary insurer (including Medicaid, Medicare, veteran's benefits, and private insurers)

Plan name\* \_\_\_\_\_

Phone number for customer service\* \_\_\_\_\_ Name of policyholder\* \_\_\_\_\_

Policyholder date of birth \_\_\_\_\_ Policyholder relation to patient \_\_\_\_\_

Group number \_\_\_\_\_ Policy ID number\* \_\_\_\_\_

### Secondary/supplemental insurer

Plan name\* \_\_\_\_\_

Phone number for customer service\* \_\_\_\_\_ Name of policyholder\* \_\_\_\_\_

Policyholder date of birth \_\_\_\_\_ Policyholder relation to patient \_\_\_\_\_

Group number \_\_\_\_\_ Policy ID number\* \_\_\_\_\_



**SECTION 4 – ONGENTYS® PRESCRIPTION INFORMATION FOR PATIENT ASSISTANCE PROGRAM**

I would like to enroll my patient into the Amneal Patient Assistance Program

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Check Medication and Strength:

ONGENTYS® 25 mg

ONGENTYS® 50 mg

Directions: \_\_\_\_\_

Quantity: \_\_\_\_\_ per 30-day supply      Refills: \_\_\_\_\_

Other Medications (if applicable) \_\_\_\_\_ Known Drug Allergies (if applicable) \_\_\_\_\_

**SECTION 5 – ONGENTYS® PRESCRIPTION INFORMATION FOR ONE-TIME 30-DAY COMPLIMENTARY SUPPLY**

I would like to enroll my patient into the One-time 30-Day Complimentary Supply.

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Check Medication and Strength:

ONGENTYS® 25 mg

ONGENTYS® 50 mg

Directions : \_\_\_\_\_

Quantity: \_\_\_\_\_ per 30-day supply

Other Medications (if applicable) \_\_\_\_\_ Known Drug Allergies (if applicable) \_\_\_\_\_

**SECTION 6 – CLINICAL INFORMATION**

Diagnosis ICD-10 :

G20 Parkinson’s disease

G21.3 Postencephalitic Parkinsonism

G21.2 Secondary Parkinson’s due to other external agents

Other \_\_\_\_\_

**SECTION 7 - PRACTITIONER INFORMATION AND ATTESTATION: (PLEASE PRINT CLEARLY)**

Prescriber Name: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_

Prescriber State License #: \_\_\_\_\_

Prescriber Phone Number: \_\_\_\_\_

Prescriber Address \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

Prescriber Fax Number: \_\_\_\_\_

Collaborative Prescriber (Printed): \_\_\_\_\_

Collaborative Prescriber NPI: \_\_\_\_\_

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 Support Services 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.

Prescriber Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

**\*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.**

