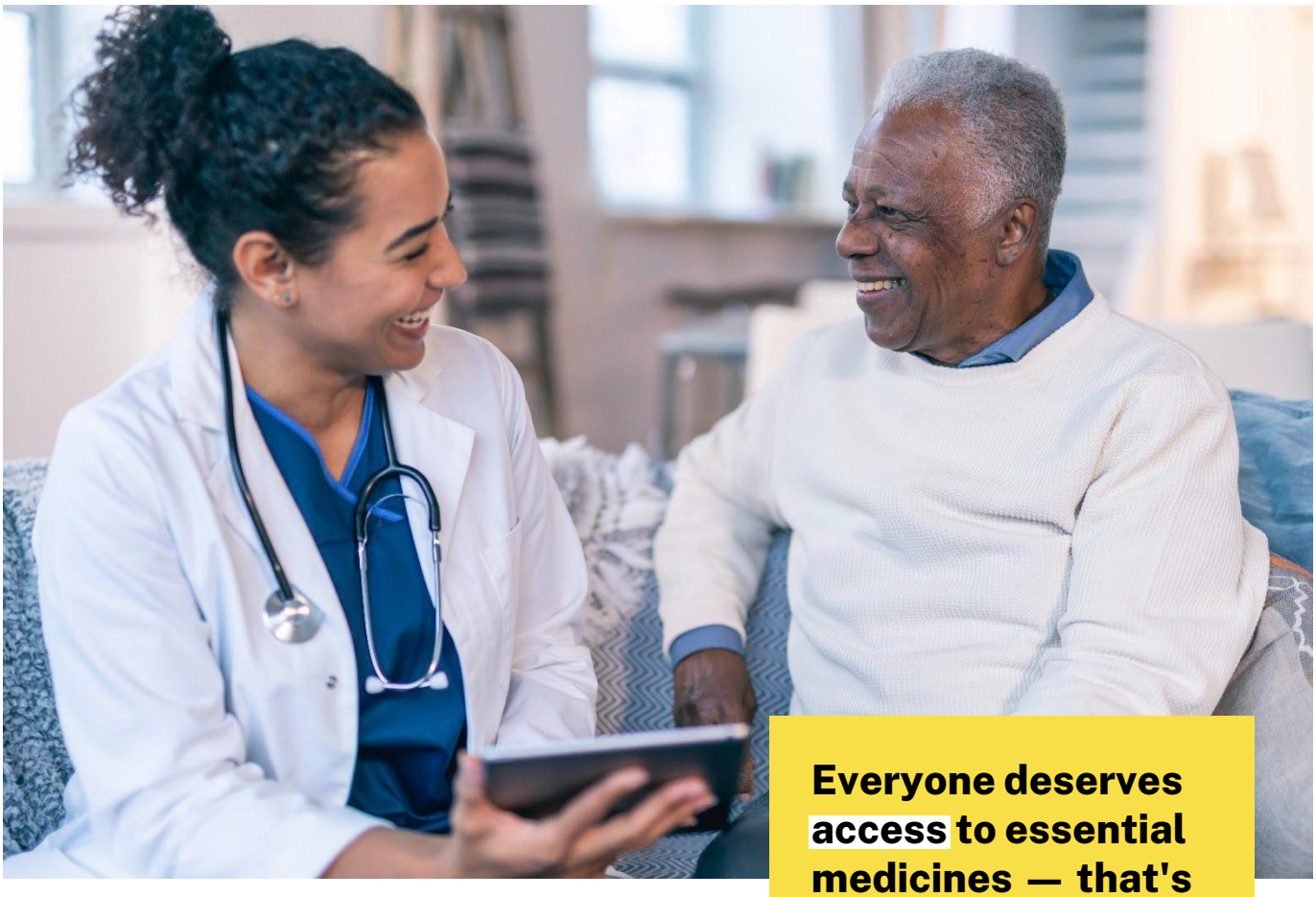
THE AMNEAL PATIENT SUPPORT SERVICES PROGRAM



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

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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 CREXONT® (carbidopa and levodopa) extended-release 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 CREXONT® to start their therapy. To be considered eligible for a one-time 30-Day Supply of CREXONT®, 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 CREXONT® and for free medication for up to one year of CREXONT® 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**.

CREXONT® (carbidopa and levodopa) extended-release 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 CREXONT® (carbidopa and levodopa) extended-release 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 (Section1)
  - Insurance Information (Section2)
  - Patient Authorization (Section3)
- 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

CREXONT 35/140 mg ER Capsules 120*
CREXONT 52.5/210 mg ER Capsules 120*
CREXONT 70/280 mg Capsules 120*
CREXONT 87.5/350 mg ER Capsules 120*

*If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form. CREXONT® (carbidopa and levodopa) extended-release capsules in the following strengths 35/140 mg, 70/210 mg, 52.5/280 mg, 87.5/350 mg (available in a 30-, 60- or 90-day supply)

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Section 1 - WELCOME TO THE AMNEAL PATIENT SUPPORT SERVICES FOR CREXONT (carbidopa and levodopa) extended-release 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:

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

**Gender is defined as sex at birth

SECTION2-PATIENT INSURANCE INFORMATION (REQUIRED) PLEASE COMPLETE ALL THAT APPLY AND INCLUDE FRONT AND BACK COPY 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*_____

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

By signing below, I authorize my healthcare provider(s) and health insurer(s) to disclose and re-disclose any 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 support services program service providers and authorized agents (collectively, the "Assistance Group") for purposes of my enrollment and participation, in the Amneal Patient Support Services Program (the "Program".) and for any additional necessary uses such as payment information, evaluation for eligibility and analytics, etc. In turn, I authorize the Assistance Group to use and to disclose My Information to my healthcare provider(s) and health insurer(s), and to the Centers for Medicare and Medicaid Services ("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. I understand that I may decline to sign this form and that will not affect the way my healthcare 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 in writing to the Amneal Patient Support Services Program (PO Box 362 Columbus, OH 43216), fax 1-614-455-0883, or by calling 1-855-459-9909 and following up within 1 business day in writing to the address or fax number listed.

If I do not cancel the Authorization in writing, 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. A revocation will not apply to instances where the disclosure has already occurred in reliance on the Authorization. The Individual's revocation of the Authorization will not apply in instances in which the Covered Entity has acted in reliance on the Authorization.

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: _____

PATIENT INFORMED CONSENT TO TERMS AND CONDITIONS OF PATIENT SUPPORT SERVICES 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 Support Services 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:	Patient Signature:	Date:
Name of Legal Representative:	Legal Representative Signature:	Date:

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SECTION 4 – CREXONT® 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:

☐ CREXONT® 35/140 mg
☐ CREXONT®52.5/210 mg
☐ CREXONT® 70/280 mg
☐ CREXONT®87.5/350 mg

Directions:_____

Quantity: _____per 30-day supply Refills:_____

Other Medications (if applicable) _____Known Drug Allergies (if applicable) _____

SECTION 5 – CREXONT® 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:

☐ CREXONT® 35/140 mg
☐ CREXONT®52.5/210 mg
☐ CREXONT® 70/280 mg
☐ CREXONT®87.5/350 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
☐ G21.2 Secondary Parkinson's due to other external agents
☐ G21.3 Postencephalitic Parkinsonism
☐ 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.**

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