Qudexy® XR
(topiramate) extended-release capsules

ACCESS PATHWAYS™ PROGRAM

Enrollment Form Instructions & Patient Consent

HEALTHCARE PROVIDER INSTRUCTIONS: To enroll your patient, please follow these steps:

1. Have your patient (or patient representative) read the PATIENT CONSENT INFORMATION below. Request that the patient (or patient representative) complete the section in the ENROLLMENT FORM under "THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE PATIENT OR PATIENT REPRESENTATIVE". Then have the patient (or patient representative) sign the form in this section.
2. Complete the rest of the ENROLLMENT FORM under "THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE HEALTHCARE PROVIDER" and copy both sides of the patient's pharmacy benefit card(s), if available. Attach the patient's prescription to the last page of the enrollment form.
3. Once the ENROLLMENT FORM has been completely filled out by both you and your patient in your respective sections, send the form along with copies of the patient's pharmacy benefit card(s) (both front and back) and prescription via fax to 1-855-637-4954 or by mail to PO Box 42458, Cincinnati, OH 45242. Separately, please provide your patient with the PATIENT CONSENT INFORMATION pages. Your patient will soon be contacted. If you have any questions, please call 1-855-282-4887.
4. Prior authorization assistance will only be provided for the on-label use of Qudexy XR and Topiramate Extended-Release Capsules. Medicare, Medicaid and other federal or state program health care patients may be ineligible for certain other aspects of the QUDEXY XR ACCESS PATHWAYS PROGRAM.

PATIENT CONSENT INFORMATION:

Please read the following. If you agree, sign and date the corresponding section of the ENROLLMENT FORM.

Authorization to Share Health Information and Participate in QUDEXY XR ACCESS PATHWAYS PROGRAM

By signing this Authorization, I authorize my healthcare provider, my health and prescription insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Upsher-Smith Laboratories, Inc., and companies working with Upsher-Smith Laboratories, Inc., including Triplefin LLC (collectively, "Upsher-Smith"), health information relating to my medical condition, treatment, and insurance coverage to provide me with support services (and related information and materials) related to Qudexy XR and Topiramate Extended-Release Capsules ("Upsher-Smith Products"), and conduct data analytics and other business activities related to such services. Once my health information has been disclosed to Upsher-Smith, I understand that federal privacy laws no longer protect the information. However, Upsher-Smith agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations.

Additionally, I authorize Upsher-Smith to provide me with support services related to Upsher-Smith Products, including, but not limited to: online support, financial assistance services, benefits verification, prior authorization, compliance and persistency and other therapy support services as well as any information or materials related to such services (the, "QUDEXY XR ACCESS PATHWAYS PROGRAM"). I also authorize Upsher-Smith to contact me to provide such services and information by mail, e-mail, fax, telephone call, text message, and other mutually agreed upon means. I also authorize Upsher-Smith to use my health information in connection with the support services related to Upsher-Smith Products and as part of the QUDEXY XR ACCESS PATHWAYS PROGRAM, including, without limitation, sharing such information with Healthcare Entities. I understand that I may refuse to sign this Authorization. I further understand that my treatment (including with Upsher-Smith Products), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive QUDEXY XR ACCESS PATHWAYS PROGRAM service benefits.

I may cancel this Authorization at any time by mailing a letter to: PO Box 42458, Cincinnati, OH 45242. Canceling this Authorization will end my consent to further disclosure of my health information to Upsher-Smith by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this Authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance.

This Authorization expires five (5) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I understand I have a right to have a copy of this form.

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The following sections should be completed by the **Patient or the Patient's Representative**

Patient Information

Name_____

Address_____

City_____ State_____ Zip_____

Gender: ☐ Male ☐ Female Date of Birth_____

Email_____

Home Phone_____ Cell Phone_____

Preferred Pharmacy Name_____ Pharmacy Phone_____

Prescription Drug Coverage & Insurance Information

Please check the following that best describes the patient's coverage

Insurance Type: ☐ Commercial ☐ Medicare Part D ☐ Medicaid
☐ No Insurance ☐ Other *(please indicate)*_____

Patient has Secondary Insurance ☐ Yes ☐ No

Plan Name_____ Policy Holder Name_____

Member #_____ Group #_____ RxBin #_____

RxPCN #_____ Insurance Company Phone _____

Insurance Company Fax_____

Attach copies of both sides of patient's prescription drug benefit card used for pharmacy claims

Authorization to Share Health Information and Participate in QUDEXY XR ACCESS PATHWAYS PROGRAM

I have read and understand the complete Authorization to Share Health Information and Participate in QUDEXY XR ACCESS PATHWAYS PROGRAM on the patient consent information sheet and agree to the terms.

Signature of Patient or Patient Representative_____ Date_____

If signed by patient representative, please explain authority to act on behalf of the patient

_____

(optional) I authorize the disclosure of my health information to the following designated individuals:

Designated Individual *(print name)*_____ Relationship_____

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The following sections should be completed by the **Healthcare Provider**

Upsher-Smith Product Support Requested

☐ QUDEXY® XR (Topiramate Extended-Release Capsules) *30 day supply*

☐ TOPIRAMATE Extended-Release Capsules *30 day supply*

Prescriber Information

Name_____

Address_____

City_____ State_____ Zip_____

NPI #_____ Specialty_____

Office Contact Name_____

Phone_____ Fax_____

Email_____

Diagnosis: *to be completed by physician only*

ICD-10 Code _____

Additional Clinical Information

Progress Notes: Including brand and/or generic medications tried/failed and duration:

Provide additional documentation if available.

HEALTHCARE PROVIDERS: *Please attach the following documents*

1. Patient's prescription for Qudexy XR or Topiramate Extended-Release Capsules or electronically prescribe to E-Scribe (NABP) 1487582. For questions on e-prescribe, please contact CompleteCare pharmacy at 877-854-3060.
2. Copies of the patient's pharmacy benefits card(s) front and back, if available.

Authorized Provider

I authorize Upsher-Smith, on behalf of my patient, to forward to the pharmacy and/or insurer the diagnosis information, which I have provided, and/or any financial information, along with other pertinent information required by the insurer for the purpose of conducting a benefit verification and/or submitting a prior authorization on my behalf.

Prescriber Signature_____Date_____

Please submit completed forms by fax to 1-855-637-4954 or by mail to PO Box 42458, Cincinnati, OH 45242