# EPIDIOLEX® (cannabidiol)

# Patient Support Program
*Start Form*

Jazz Cares®
Making a difference in Patients' lives, one Patient at a time

☐ **Requesting EPIDIOLEX Quick Start for New Patient** ☐ **Requesting Prior Authorization Follow-up and Appeals Process Support**

Complete all requested information below to help your patients get started on treatment. **All fields are required,** unless the information is being provided on an accompanying EMR face sheet (or the like). If submitting directly to a Specialty Pharmacy, the appropriate prescription, in accordance with state-specific requirements, must be submitted separately from this start form.

## SECTION 1: PATIENT INFORMATION

Patient First Name: _____ Middle Initial:_____ Last Name: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female Height: _____ Weight:_____kg
Current Medications:_____
Known Allergies: _____ ☐ No Known Allergies

**Diagnosis:** The diagnosis designations below are intended to ensure communication of accurate information to your patient's insurance plan. **EPIDIOLEX is approved to treat seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex in patients 1 year of age and older.**

**Please click for full Prescribing Information**

**ICD-10 Code:** _____ **Preferred Specialty Pharmacy:** _____

**Seizures associated with:** ☐ Lennox-Gastaut syndrome ☐ Dravet syndrome ☐ Tuberous sclerosis complex ☐ Other (please specify):_____

If choosing "Other," and this medication is being prescribed for a use that is not listed on the FDA-approved label, by signing this patient start form and initialing here, I certify that the Prescriber has determined that EPIDIOLEX is medically necessary and appropriate for this patient and this patient's treatment will be supervised.

**Healthcare Provider's Initials:** _____
**Date:** _____

☐ **EPIDIOLEX Quick Start for New Patient**:

This offer may be used by new-start EPIDIOLEX patients with commercial insurance and patients who are eligible for or participate in federal healthcare programs such as Medicaid, Medicare, or any similar federal or state programs. For full eligibility requirements, go to www.epidiolexhcp.com. **Offer valid when accompanied by appropriate prescription for FDA-approved indication.** I request a Quick Start (up to 60 days) supply of EPIDIOLEX for my patient.

Patient Address: _____ City/State/ZIP Code:_____
Group Home/Long-term Care Facility? ☐ Y ☐ N If Yes, Facility Name and Contact: _____
Full Name(s) of Legal Guardian(s):_____
Primary Phone: _____ ☐ Home ☐ Mobile ☐ Other ☐ Email: _____
Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Other

## SECTION 2: INSURANCE INFORMATION *(only required if submitting directly to a Specialty Pharmacy)*

***Please provide a copy of the front and back of all prescription and medical benefit insurance cards.***

**Prescription Drug Insurance Provider:** ☐ **Patient Has No Prescription Drug Coverage**
Insurer Name: _____ Insurer Phone: _____
Rx ID #: _____ Rx BIN: _____ Rx PCN: _____
Rx Group #: _____ Cardholder Name: _____ Date of Birth: _____
Patient's Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Does the Patient Have Other Health Insurance? ☐ Y ☐ N
**Other Insurance Provider Name:** _____
Policy ID #: _____ Group #: _____
Insurer Phone: _____ Cardholder Name: _____ Date of Birth: _____
Patient's Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

## SECTION 3: HEALTHCARE PROVIDER INFORMATION AND AUTHORIZATION

Prescriber Name: _____ Title:_____ Specialty: _____ DEA #:_____
NPI #: _____ State License #: _____ Tax ID #: _____ Medicaid Provider #:_____
Practice Name: _____ Office Contact Name: _____ Contact Phone: _____
Contact Fax: _____ Contact Email:_____
Preferred Method of Contact: Primary: ☐ Phone ☐ Fax ☐ Email Secondary: ☐ Phone ☐ Fax ☐ Email

Office Address: _____ City/State/ZIP Code: _____

As the undersigned Prescriber, or the Prescriber's Designated Agent, I hereby authorize the use or disclosure of the patient's health information contained on this start form to the patient's other healthcare providers (including pharmacies and Jazz Pharmaceuticals, Inc.); their respective agents, contractors, and other designees that are involved in the patient's treatment ("Providers"); and health plans or insurers and their respective agents and designees ("Insurers") to: (1) determine the patient's insurance benefits for EPIDIOLEX; (2) transmit the necessary information to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (3) contact the patient to obtain any necessary signatures, consents, or information relating to the patient's treatment*; (4) contact the patient in order to ask whether the patient would like to apply for the Jazz Pharmaceuticals Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; and (5) to provide other related care coordination services.

I certify that the patient's authorization to use and disclose the patient's personally identifiable health information for the purposes permitted under this "Healthcare Provider Authorization" section has been obtained, as required by HIPAA. I agree that the patient's Providers and Insurers may contact the Prescriber or the Designated Agent, as applicable, for additional information as needed relating to the patient's EPIDIOLEX therapy. The undersigned certifies that: (1) the Prescriber has prescribed EPIDIOLEX for the identified patient; (2) the Prescriber has determined that EPIDIOLEX is medically necessary for this patient; (3) if the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.

**Signature:** _____ **Date:** _____ **Name/Title (if Designated Agent):** _____

*If legal guardian/patient is unavailable to provide a signature on Page 2, the JazzCares® Team will contact the legal guardian/patient to obtain authorization.

**EPIDIOLEX® (cannabidiol) Quick Start**

☐ **Fax the completed form and a valid prescription to: JazzCares® 1-855-518-7566**

☐ **Submit eRx to: PharmaCord, 11001 Bluegrass Parkway, Suite 200 Louisville, KY 40299**

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**Benefits investigation and verification | Prior authorization and appeals support | In-network pharmacy finder | Financial support programs**

**Fax the completed form, as well as the front and back of the patient's insurance cards, to: JazzCares 1-855-518-7566**

## SECTION 4: HIPAA PATIENT AUTHORIZATION

**(For additional assistance, call us at 1-833-426-4243. Please click for full Prescribing Information.)**

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose the following information ("Personal Information") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs.

I understand and authorize Jazz Pharmaceuticals to use and further disclose the Personal Information it receives as a result of this Form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the JazzCares program or any other Jazz-affiliated patient support services and activities related to my condition or treatment; (ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products; (iii) coordinating my receipt of and payment for Jazz Pharmaceuticals' products; (iv) contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my Personal Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (vi) de-identifying my Personal Information by aggregating it for research purposes; (vii) managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand and authorize Jazz Pharmaceuticals to contact me using the contact information provided to Jazz to enroll me in, operate, and administer any Jazz-sponsored patient support services, including the JazzCares program, through a variety of means including email, postal mail, phone, fax or SMS/text unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Jazz contact me by telephone or SMS/text.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Jazz Pharmaceuticals may create or receive. I understand that my health insurer(s), Pharmacy, and third-party vendor(s) may receive remuneration (payment) in exchange for disclosing my Personal Information to Jazz Pharmaceuticals (including JazzCares), its affiliates, and vendors who help provide the services) and/or for providing me with support services for the purposes described above.

I understand that after my Personal Information is transmitted to Jazz Pharmaceuticals, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, Jazz Pharmaceuticals will not disclose my Personal Information to a third party that is not related to the patient support programs (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my Personal Information, I understand the receiver may not be subject to HIPAA or other privacy laws and the Personal Information might be re-disclosed by the recipient.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s) and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I can revoke this Form at any time in the future, but if I do so, I may no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

I understand that should I revoke this Form, the revocation will not impact uses and disclosures of my Personal Information that have already occurred in reliance on this Form. This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares program, unless a shorter time is required by state law. I can also revoke it earlier by calling 1-855-518-7566 or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589. I understand the program may be changed or ended at any time without prior notification. I understand I may request a copy of this Form that is on file with Jazz.

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at https://www.jazzpharma.com/privacy-statement/. If you are a resident of California, a description of the personal information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: https://www. jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/. I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient Name: _____

Name (if Different from Patient): _____ Relationship to Patient: _____

Signature of Patient or Legal Guardian, if Applicable: _____ Date: _____


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