NOURIANZ® (istradefylline) Patient Assistance Program Application

Phone: 833-KK-CARES (833-552-2737) | **Fax:** 833-447-4399 | M-F, 8AM to 5PM EST
Mailing Address: Attn: Kyowa Kirin Cares, 50 Bearfoot Rd, Northborough, MA 01532

PAP Application must be completed in full, including signatures, to be reviewed for patient program eligibility.

- To be considered for the Patient Assistance Program, all applicants must satisfy the following requirements and eligibility criteria:
  - » Complete the Financial Information section below, attach Proof of Income documentation, and qualify for the program financial requirements.
  - » Be a permanent resident of the United States or Puerto Rico.
  - » Be fully uninsured (no health insurance or prescription drug insurance whatsoever).
  - » Requested product must be prescribed by a licensed U.S. healthcare professional for the Food and Drug Administration (FDA) approved indication.
- Applicants are individually assessed for program eligibility based on information provided within this application, and are only evaluated upon receipt of the completed and signed application.

** Indicates a required field*

1. Patient Information

*Patient First Name: _____ MI: _____

*Patient Last Name: _____

*DOB: _____ *Gender: ☐ M ☐ F ☐ Unspecified

Last 4 SSN: _____

*Preferred Language: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

*Home Phone: _____ Cell Phone: _____

Email: _____

Caregiver Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Email

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

2. Prescriber Information

*Prescriber Name: _____ ☐ MD ☐ NP ☐ DO ☐ PA

Prescriber NPI #: _____ *SLN: _____

Facility Name: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone #: _____ Fax #: _____

*Office Contact Name: _____

Office Contact Email: _____

3. Financial Information

*Total Annual Gross Household (HH) Income: $ _____

*Household Size (select one): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ _____

*Select Your Sources of Income: ☐ Salary/Wages ☐ Alimony/Child Support

☐ SS Pension/Unemployment ☐ Retirement ☐ SSDI ☐ SSI

Please attach related documentation as Proof of Income to be reviewed for eligibility.

☐ No Household Income *($0 – Provide a signed letter from the patient explaining zero income)*

☐ Other: _____

4. Clinical Information

*ICD 10: ☐ G20 Parkinson's Disease ☐ Other _____

*Allergies: _____

*Is the patient currently taking Levodopa/Carbidopa?: ☐ Yes ☐ No

*Current Meds: _____

_____

5. Prescriber Certification

I certify that the information provided in this Patient Assistance Program Application is complete and accurate to the best of my knowledge, that I have prescribed NOURIANZ® below to the applicant based on my professional judgment of medical necessity for a Food and Drug Administration (FDA) approved indication, and that I will supervise the patient's medical treatment. I will notify Kyowa Kirin Cares immediately if the Kyowa Kirin product is no longer medically necessary for this patient's treatment. I certify that I have obtained from my patient all required written authorizations for the release of my patient's personal identification and insurance information to Kyowa Kirin and their agents and representatives. I understand that any information provided is for the sole use of Kyowa Kirin and their agents and representatives to assess patient's eligibility for participation in the Kyowa Kirin Cares Patient Assistance Program and to otherwise administer the Program and provide related services. I understand that application to the Program does not guarantee that assistance will be obtained. I understand that Kyowa Kirin may change or cancel this program at any time. I understand that if my patient's financial and/or insurance status changes, the patient may no longer be eligible for the Program, and I agree to immediately notify a Kyowa Kirin Cares representative if I become aware of changes in the patient's insurance status. I agree that Kyowa Kirin Cares may contact me for additional information relating to this application either by fax, e-mail and/or telephone. I understand that I am under no obligation to prescribe an Kyowa Kirin product and that I have not received, nor will I receive any benefit from Kyowa Kirin or their agents or representatives for prescribing a Kyowa Kirin product. I agree that I will not submit claims or make any attempt to receive reimbursement for product provided by the Program. By signing this Patient Assistance Program Application, I authorize the release of medical and/or other patient information relating to NOURIANZ® therapy to agents, and service providers of Kyowa Kirin (including but not limited to NOURIANZ® dispensing pharmacies) to use and disclose as necessary for verification of patient eligibility, and to furnish any information on this form to the insurer of the applicant for the purpose of verifying benefit eligibility.

6. Prescription for NOURIANZ®

Rx: NOURIANZ®

Dispense: (Please select one option below)

☐ 20 mg tablets or ☐ 40 mg tablets

Quantity: ☐ 90 tablets ☐ ___ tablets

SIG: Take one (1) tablet daily Refills #: _____

Please sign and date below:

*Prescriber Signature: _____

Substitution Permitted: ☐ Yes ☐ No

*Date: _____

*STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY -*If required by applicable law, please attach copies of all prescriptions on official state prescription forms*

Please see Important Safety Information for NOURIANZ on page 3. Please click here for Patient Information for NOURIANZ.

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Patient Name: _____ DOB: _____ * *Indicates a required field*

7. Patient Authorization and Agreement

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for NOURIANZ® and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Kyowa Kirin, its affiliated companies vendors, agents, collaboration partners, and representatives (together, "Kyowa Kirin") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting Kyowa Kirin Cares Support Services (the "Program") for Healthcare Providers and patients for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

a. Enroll me in and contact me about the Program and financial assistance services available.

b. Verify that I do not have prescription drug coverage for NOURIANZ®

c. Contact me and leave messages about my use of NOURIANZ® and my medical care,

d. Coordinate prescription fulfillment and share prescription information,

e. Conduct surveys, data analytics, market research and other internal business activities related to the Program, NOURIANZ®, and other Kyowa Kirin products and programs, and

f. Contact me as otherwise required or permitted by law

I understand that pharmacies that ship my medication may be paid to share this information with the Program to help provide the offerings requested for me. Once my Protected Health Information has been disclosed to Kyowa Kirin, I understand that federal privacy laws no longer protect the information. However, Kyowa Kirin agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided by Kyowa Kirin under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

This Authorization will last for a period of five (5) years (unless earlier termination is required by applicable state law). I understand that I may cancel this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by mailing a request to Attn: Kyowa Kirin Cares, 50 Bearfoot Rd, Northborough, MA 01532; via fax at 833-447-4399, or by calling 833-552-2737. I understand that revoking this authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

The personal and health insurance I have provided on this form is complete and accurate to the best of my knowledge . I will update my information promptly if any of the infromation reflected on this Form changes by contacting the Program at 833-552-2737.

My signature certifies that I have read and understand the above statements, and agree to the outlined terms.

*Patient Name: _____ *Signature: _____ *Date: _____
Please Print

8. Patient Authorized Representative

I permit Kyowa Kirin Cares Support Services representatives to speak with the following person about this enrollment form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues relating to my enrollment or any other treatment related issues. I may cancel this authorization at any time by calling: 833-552-2737.

Name of Authorized Representative: _____ Relationship to Patient: _____

Phone Number: _____ Email: _____

By signing below, I, the patient named above, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

*Patient Signature: _____ *Date: _____

Please see Important Safety Information for NOURIANZ on page 3. Please click here for Patient Information for NOURIANZ.

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What is NOURIANZ?

NOURIANZ is a prescription medicine used with levodopa and carbidopa to treat adults with Parkinson's disease (PD) who are having "off" episodes.

IMPORTANT SAFETY INFORMATION

Before you take NOURIANZ, tell your healthcare provider about all your medical conditions, including if you:

- have a history of abnormal movement (dyskinesia)
- have a history of psychotic thinking or behavior
- have reduced liver function
- smoke cigarettes or use other tobacco products
- are pregnant or plan to become pregnant. NOURIANZ may harm your unborn baby
- are breastfeeding or plan to breastfeed

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

NOURIANZ and other medicines may affect each other causing side effects. NOURIANZ may affect the way other medicines work, and other medicines may affect how NOURIANZ works.

What are the possible side effects of NOURIANZ?

NOURIANZ may cause serious side effects, including:

- **uncontrolled sudden movements (dyskinesia).** Uncontrolled sudden movements is one of the most common side effects.
- **hallucinations and other symptoms of psychosis.** NOURIANZ can cause abnormal thinking and behavior, including:
  - being overly suspicious or feeling people want to harm you (paranoid ideation)
  - believing things that are not real (delusions)
  - seeing or hearing things that are not real (hallucinations)
  - confusion
  - increased activity or talking (mania)
  - disorientation
  - aggressive behavior
  - agitation
  - delirium (decreased awareness of things around you)
- **unusual urges (impulse control or compulsive behaviors).** Some people taking NOURIANZ get urges to behave in a way unusual for them. Examples of this are unusual urges to gamble, increased sexual urges, strong urges to spend money, binge eating, and the inability to control these urges.

If you notice or your family notices that you are developing any new or unusual symptoms or behaviors, talk to your healthcare provider.

The most common side effects of NOURIANZ include uncontrolled movements (dyskinesia), dizziness, constipation, nausea, hallucinations, and problems sleeping (insomnia).

These are not all the the possible side effects of NOURIANZ.

Please click here for Patient Information for NOURIANZ.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088 or www.fda.gov/medwatch