KYNMOBI®
(apomorphine HCl) sublingual film
10 mg • 15 mg • 20 mg • 25 mg • 30 mg

FOR LONG-TERM CARE:

Prescription & Enrollment Intake Form

PharMerica®

Please fax completed form to:
1.866.470.1341

Before faxing this completed form, please also include: ❑ **Medication List** ❑ **FACE Sheet**

STEP 1: Complete Facility and Physician Information

FACILITY INFORMATION

Facility Name: _____

Primary Point of Contact: _____ Cell / Direct Phone: _____

Secondary Contact: _____ Cell / Direct Phone: _____

Facility Address: _____ City/County: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Fax: _____

Work Phone : _____ Cell Phone: _____

State License #: _____ National Provider ID: _____

STEP 2: Complete Patient Information and ICD-10 Code

PATIENT INFORMATION (Please provide a copy of the patient's facility FACE Sheet and Medication List)

❑ Policyholder same as patient: _____

Patient Name: _____ Date of Birth: _____ Sex: ❑ M ❑ F

Diagnosis and ICD-10 Code: _____

STEP 3: Prescription Drug Coverage Information

INSURANCE ❑ Policyholder same as patient

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Insurance Phone Number: _____

Patient First Name: _____ Patient Last Name: _____

❑ No Insurance ❑ Secondary insurance available

STEP 4: Check box to initiate KYNMOBI (apomorphine HCl) sublingual film Patient Starter Kit

PRESCRIPTION
RX: KYNMOBI—ADMINISTER DOSES AS DIRECTED
❑ Initial prescription = Patient Starter Kit includes:
- KYNMOBI Titration Kit: 2 individually packaged films of each dose strength, for a total of 10 films
- A Patient Starter Guide with a dose tracker

Notes: _____

OR

Prescribe KYNMOBI dose strength

RX: KYNMOBI 30-COUNT CARTON
❑ 10 mg ❑ 15 mg ❑ 20 mg ❑ 25 mg ❑ 30 mg Refills: _____

DOSING OBSERVATION & MONITORING (please check one)
❑ **No.**

Requesting Nursing Services? If YES, please check this box

❑ **Yes.** I certify that the information in this form is accurate and complete to the best of my knowledge and that KYNMOBI and these Dosing Observation and Monitoring visits are medically appropriate for my patient. I also certify that I have fully read the KYNMOBI prescribing information, including contraindications and risks, and have determined that use of KYNMOBI is appropriate for this specific patient. I understand that all offerings, including the first dose observation and nurse education, through the Dosing Observation and Monitoring Program, are being provided at no cost and on a complimentary basis from Sunovion in order to support access to care and appropriate care coordination. I further understand that my decision to participate in the Dosing Observation and Monitoring Program is not conditional on any requirement to purchase or prescribe KYNMOBI or any other products manufactured by Sunovion. In addition, I agree that I have not, and will not, submit, or cause to be submitted, any claims for payment or reimbursement to any third-party payor, including any federal healthcare program, such as Medicare or Medicaid, for the value of any doses of KYNMOBI or other support that may be provided through the Dosing Observation and Monitoring Program. If I am or become in possession of free KYNMOBI that has been provided through the Dosing Observation and Monitoring Program, I will not sell, trade, or attempt to sell or trade such product. I further understand that Sunovion will utilize PharMerica for the nurse support offered through the Dosing Observation and Monitoring Program and Sunovion disclaims all liability for any actions or inactions of this vendor. I will comply with all applicable terms and conditions for the Dosing Observation and Monitoring Program and understand that such support may be amended, rescinded, or revoked at any time without notice. I authorize PharMerica on behalf of my patient to enroll the patient in the Dosing Observation and Monitoring Program. PharMerica may contact me regarding the information on this form and as needed to facilitate my patient's enrollment and participation in the Dosing Observation and Monitoring Program.

Sign Statement of Medical Necessity

I CERTIFY KYNMOBI THERAPY IS NECESSARY FOR THIS PATIENT.
PLEASE SIGN BELOW:

Prescriber's Signature (No stamps please): _____

Date: _____

For product-related questions, please contact Sunovion Medical Information at **1.800.739.0565**. Please note, Sunovion Medical Information will not provide treatment recommendations or provide specific patient care instructions.

Pharmacy Questions?
Call PharMerica Specialty at 800.678.7575 or email indianapolis.specialty@pharmerica.com

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1.866.470.1341