RYTARY®
(carbidopa and levodopa)
EXTENDED-RELEASE CAPSULES
23.75 mg/95 mg • 36.25 mg/145 mg
48.75 mg/195 mg • 61.25 mg/245 mg

Patient Enrollment Form

MyRYTARY®
PATIENT SUPPORT PROGRAM

Phone: 1-844-467-2928 fax: 1-844-467-2908 Puerto Rico fax: 1-412-229-2907 MyRYTARY.com

INSTRUCTIONS FOR PATIENTS

By completing this form:

- You will enroll in support services from Amneal Pharmaceuticals LLC
- You can apply to the MyRYTARY® Patient Support Program to determine if you are eligible to receive RYTARY free of charge
- You will consent to the use and disclosure of some of your personally identifiable information (PII), including health information. We will use and disclose information only to the extent necessary to provide the services you have requested

We can start assisting you once this form is sent back to us by your healthcare provider on your behalf.

You can choose not to sign this form. However, please note that we cannot assist you without your signed authorization.

To obtain assistance, please follow these steps:

1. **Read** the Patient Authorization on pages 2 and 3 and the Important Safety Information on page 4.
2. If you wish to enroll in the MyRYTARY® Patient Support Program, please **fill in SECTIONS 1 and 1A** and **sign and date SECTIONS 1A and 1B** on page 5.
3. Your healthcare provider will fill out page 6 of the Enrollment Form and send the form back to us.

Be sure to fill in all information, complete all fields, and sign and date the form, or it could delay our ability to help you.

If you have any questions, talk with your healthcare provider or contact us:

Call:
1-844-467-2928
Monday-Friday, 8am-8pm EST

Visit:
MyRYTARY.com

INSTRUCTIONS FOR HEALTHCARE PROVIDERS

Please write legibly and complete all fields on the Patient Enrollment Form to prevent delays.

By completing this form, you are requesting services on behalf of your patient, which may include:

- Benefits investigation
- Assistance in navigating and understanding the payer approval process
- Finance options that may make RYTARY more affordable
- Ongoing support throughout their treatment journey

You may opt out of any of these services for your patient by contacting the MyRYTARY® Patient Support Program at 1-844-467-2928.

To enroll your patient, please follow these steps:

1. Have your patient read the Patient Authorization on pages 2 and 3 and the Important Safety Information on page 4.
2. Have your patient read, sign, and date SECTIONS 1A and 1B on page 5.
3. Complete page 6 and sign and date the Physician Attestation.
4. **This form cannot be processed without a signature and date from both the prescriber on page 6 and the patient on page 5.**
5. Fax pages 5 and 6 of the Enrollment Form to 1-844-467-2908, or 1-412-229-2907 in Puerto Rico.

Please see Important Safety Information on page 4 of this form.
Full Prescribing Information is available at http://documents.impaxlabs.com/rytary/pi.pdf.

PATIENT AUTHORIZATION

Please read the following carefully. If you agree, sign and date SECTION 1A of the Enrollment Form.

The MyRYTARY® Patient Support Program (the "Program") is available free of charge from Amneal Pharmaceuticals LLC. If you don't have a healthcare plan, or if your healthcare plan won't pay for your prescribed treatment, and you meet certain financial and medical standards, we will work with you and your physician(s) to find possible sources of reimbursement for your prescribed RYTARY treatment.

Before we can begin the process of assisting you, we need to collect, use, and disclose your Protected Health Information (PHI). Protected Health Information includes any information related to your healthcare insurance or plan benefits, including coverage limits; all health records related to your treatment, including possible sensitive material relating to sexually transmitted diseases, mental health conditions, and/or genetic testing; and any information that has a bearing on your health or whether you're staying on your medicine or treatment. Although we are not looking for PHI that is unrelated to your treatment, it may be part of the health records sent to us.

When signed by you, this form permits your PHI to be released to us by your doctors, your healthcare plan or insurance company, your pharmacies, or others who might hold your PHI. Once you sign this form and it is sent back to us, we can use and disclose the released health information as needed to provide the support services described below.

You do not have to sign this consent, but we cannot provide our services without it. You might need to pay for your RYTARY product on your own, whether you sign this form or not.

PLEASE READ THE FOLLOWING VERY CAREFULLY. IF YOU HAVE ANY QUESTIONS, CALL US AT 1-844-467-2928.

By signing this form, I authorize my doctors, my healthcare plan or insurance company, and my pharmacies to release my PHI (as defined above) to vendors and business partners of Amneal Pharmaceuticals LLC who are performing services related to the Program (collectively, the "Amneal Group") so that the Amneal Group may: help determine my healthcare plan coverage for RYTARY treatments prescribed by my doctor and other procedures as part of my therapy on RYTARY; identify or make me aware of alternative sources of funding for such treatment, including third-party nonprofit organizations and programs; track my use of prescribed RYTARY; contact me (using the contact information I am providing on this form) to collect any additional information needed to provide these services to me; or measure and track the quality of services performed by Program staff. I understand that signing this Authorization is voluntary, but that without my signature I will not be able to participate in the Program. Further, non-participation will neither affect my healthcare treatment (including treatment with RYTARY), nor my health insurance coverage.

I understand that once my doctors, healthcare plan, or pharmacies release my PHI pursuant to this Authorization, that information may no longer be covered by Federal Privacy Law (for example, HIPAA).

This authorization allows those who rely on it to use and/or release my PHI for 1 year from the date I have signed it. I understand that I can withdraw the authorization at any time by sending a written notice to the address listed below:

MyRYTARY Patient Support Program
P.O. Box 443
Monroeville, PA 15146

My withdrawal goes into effect once it is received by the Program, but will not affect uses and disclosures made prior to that date.

I am entitled to receive a copy of this authorization after signing it on page 5.

PATIENT AUTHORIZATION

Please read the following carefully. If you agree, sign and date SECTION 1B of the Enrollment Form.

In addition to the authorization provided above for the disclosure of PHI for specific Program services described on page 2, I understand that Amneal Pharmaceuticals LLC also offers certain free patient services and RYTARY product programs related to my therapy. I would like to take part in these programs and understand that these services are optional and my decision to participate or not in these additional programs will not impact the services for which I have authorized the disclosure and use of my PHI as described on page 2. These services may include communicating with me by mail, email, and phone, and such communications may include marketing materials and offers for product training and support, other services that may become available, or requests from Amneal Pharmaceuticals LLC for my participation in market research. I also understand that Amneal Pharmaceuticals LLC may share information from my participation in these programs with my healthcare provider. I authorize such uses and disclosures of my PHI under the same terms as stated in the Authorization on page 2. To withdraw my consent, I understand that I must contact the Program in writing at the address on page 2. My withdrawal goes into effect once it is received by the Program. By signing below, I consent to these services and certify that I am at least eighteen (18) years of age. I am entitled to receive a copy of this consent once it is signed by me on page 5.

Confidentiality Notice: This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this information is not the intended recipient, or the authorized agent or individual responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy the related document.

INDICATION

RYTARY (carbidopa and levodopa) extended-release capsules is a prescription medication that contains a combination of carbidopa and levodopa for the treatment of Parkinson's disease, Parkinson's disease caused by infection or inflammation of the brain, or Parkinson's disease like symptoms that may result from carbon monoxide or manganese poisoning.

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IMPORTANT SAFETY INFORMATION

Do not take RYTARY with antidepressant medications known as nonselective monoamine oxidase (MAO) inhibitors because taking these two drugs within two weeks of each other can result in high blood pressure.

Taking RYTARY may result in falling asleep while engaged in normal activities, even without warning and as late as one year after starting RYTARY. This may affect your ability to drive or operate machinery. Do not do anything that requires alertness until you know how RYTARY affects you.

Tell your healthcare provider if you have any heart conditions, especially if you have had a heart attack or irregular heartbeats; if you experience hallucinations or abnormal thoughts and behaviors (such as excessive suspicion, believing things that are not real, confusion, agitation, aggressive behavior, and disorganized thinking), if you have intense urges to gamble, increased sexual urges, other intense urges, and the inability to control those urges; if abnormal involuntary movements appear or get worse during treatment with RYTARY; or if you have ever had a peptic ulcer or glaucoma.

The most common side effects that may occur with RYTARY include nausea, dizziness, headache, sleeplessness, abnormal dreams, dry mouth, abnormal involuntary movements, anxiety, constipation, vomiting, and low blood pressure upon rising.

Some patients taking RYTARY have experienced suicidal thoughts or have attempted suicide. Tell your healthcare provider if you have thoughts of suicide or have attempted suicide.

Notify your healthcare provider if you become pregnant or intend to become pregnant during therapy or if you intend to breast-feed or are breast-feeding an infant.

Talk to your healthcare provider before you lower the dose or stop taking RYTARY, as this may result in serious side effects. Call your healthcare provider immediately if you develop withdrawal symptoms such as fever, confusion, or severe muscle stiffness.

Take RYTARY as instructed. You may take RYTARY with or without food; however, taking RYTARY with food may decrease or delay its effect. For this reason, consider taking the first dose of the day about 1 to 2 hours before eating. Swallow RYTARY whole; do not chew, divide, or crush. If you have difficulty swallowing the capsule, twist apart both halves and sprinkle the entire contents of both halves of the capsule on a small amount of applesauce (1 to 2 tablespoons). Consume the mixture immediately. Do not store the drug/food mixture for future use.

Note: This information is intended to aid in the safe and effective use of RYTARY. It is not a disclosure of all possible adverse or intended effects. Tell your healthcare provider if you have any side effects while taking RYTARY. He or she can make adjustments that may reduce these effects.

To report SUSPECTED ADVERSE REACTIONS, contact Amneal Specialty, a division of Amneal Pharmaceuticals LLC at 1-877-835-5472 or the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please read the full Prescribing Information available at http://documents.impaxlabs.com/rytary/pi.pdf. For more information go to RYTARY.com and/or talk to your healthcare provider.

amneal

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SECTION 1: PATIENT INFORMATION

First Name

Last Name

Date of Birth (mm/dd/yyyy)

Preferred form of communication (check all that apply)

☐ Email: _____

☐ Home Phone: _____

☐ Cell Phone: _____

OK to leave detailed message? ☐ Yes ☐ No

OK to send a text message? ☐ Yes ☐ No

Best time to reach me: ☐ Morning ☐ Afternoon

Patient Preferred Language

Alternate Contact Name

Relationship to Patient

Phone

Email

1A: PATIENT AUTHORIZATION TO SHARE PERSONALLY IDENTIFIABLE INFORMATION (PII) AND PATIENT SERVICES AUTHORIZATION

I have read and understand the Authorization on page 2 and agree to the terms.

Sign here:

Signature of Patient or Personal Representative Date

Print Patient's Name

Patient/Personal Representative's Address City/State/ZIP Code

Personal Representative's Name (if applicable)

Description of the Representative's Authority

Physician's Name

Physician's Address City/State/ZIP Code

1B: PATIENT AUTHORIZATION

I have read and understand the Authorization on page 3 and agree to the terms.

Sign here:

Signature of Patient or Personal Representative Date

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PATIENT INFORMATION

First Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender ☐ Male ☐ Female

Email Address _____

Address _____

City _____ State _____ ZIP Code _____

Home Phone _____ Cell Phone _____

Medical Insurance Company _____ Phone _____

Policy # _____ Group # _____

Prescription Drug Plan Name _____ Phone _____

BIN # _____ Policy # _____

PCN # _____

PRESCRIBER INFORMATION

Prescriber First Name _____ Last Name _____

State License # _____ NPI # _____

Prescriber Phone _____

Name of Facility _____

Facility Address _____

City _____ State _____ ZIP Code _____

Office Contact First Name _____ Last Name _____

Phone _____ Fax _____

PRESCRIPTION AND DIAGNOSIS FOR RYTARY – STARTER RX

ICD-10-CM: One code must be checked.

☐ G20: Parkinson's disease

☐ G21.2: Secondary parkinsonism due to external agents

☐ G21.3: Postencephalitic parkinsonism

One dosage must be checked.

☐ 23.75 mg/**95 mg:** Carbidopa 23.75 mg and levodopa 95 mg – Capsule Extended-Release

☐ 36.25 mg/**145 mg:** Carbidopa 36.25 mg and levodopa 145 mg – Capsule Extended-Release

☐ 48.75 mg/**195 mg:** Carbidopa 48.75 mg and levodopa 195 mg – Capsule Extended-Release

☐ 61.25 mg/**245 mg:** Carbidopa 61.25 mg and levodopa 245 mg – Capsule Extended-Release

☐ Take 3 (three) capsules PO TID ☐ Take 4 (four) capsules PO TID

☐ Take 3 (three) capsules PO QID ☐ Take 4 (four) capsules PO QID

☐ Refills: 6 ☐ Refills Other: _____

Other dosing instructions: _____

If patient's symptoms are not tolerated on starter dose, please fax in new prescription to MyRYTARY at (844)467-2908.

Dispense: quantity sufficient for 14 day supply; unless specified otherwise above.

Sign here: _____ _____

Prescriber Signature (No Stamp) Date

Collaborating Physician (For mid-level practitioner) _____

☐ **DAW – Please check DAW to ensure RYTARY is dispensed as prescribed.**

PRESCRIBER ATTESTATION

By signing below, I verify that the information provided in this MyRYTARY® Patient 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 the MyRYTARY® Patient Enrollment Form or to modify or discontinue any services of assistance provided through the MyRYTARY® Patient Support Program. Finally, I authorize Lash Group, LLC ("Lash Group") as my designated agent to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through the MyRYTARY® Patient Support Program and (as applicable) to assess my patient's eligibility for copay assistance. My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Lash Group for purposes of the MyRYTARY® Patient Support Program.

Sign here: _____ _____

Prescriber's Signature Date