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

PharMerica

Prescription & Enrollment Form

PLEASE PRINT

Phone: 1-800-678-7575 Fax: 1-866-470-1341
Email: Indianapolis.Specialty@pharmerica.com

STEP 1: Complete Facility and Physician Information

Facility Information:

Facility Name: Date shipment needed:

Director of Nursing: Phone:

Secondary Nursing Contact: Phone:

Address:

City/County: State: ZIP:

Prescriber Information:

Prescriber Name: Fax:

Phone (work): (mobile):

State License #: Nat'l Provider ID:

STEP 2: Initiate KYNMOBI (apomorphine HCl) sublingual film Patient Starter Kit

(Check all boxes that apply)

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 an instructional video and dose tracker

Rx: Trimethobenzamide HCl 300 mg Capsules

☐ Quantity: 90 Refills:

Take 1 capsule by mouth 3 times daily. Begin taking 3 days prior to initial KYNMOBI dose and continue for up to 2 months if KYNMOBI is still an active medication.

1. Is trimethobenzamide being prescribed by the HCP **per the recommendations of the KYNMOBI prescribing information (Dosage and Administration)** to lessen or prevent nausea and vomiting? ☐ Yes ☐ No
2. Please check 1 of the following ICD10 codes:
   ☐ R11.2 (Nausea and vomiting) ☐ Other _____

Notes:

OR

Prescribe KYNMOBI dose strength

Rx: KYNMOBI 30-count carton _____

☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg ☐ 30 mg Refills:

Take 1 sublingual film, when needed, to treat an OFF episode. Not to exceed 5 doses per day with a minimum of 2 hours between each dose.

Rx: Trimethobenzamide HCl 300 mg Capsules

☐ Take 1 capsule by mouth 3 times daily. Begin taking 3 days prior to initial KYNMOBI dose and continue for up to 2 months if KYNMOBI is still an active medication.

1. Is trimethobenzamide being prescribed by the HCP **per the recommendations of the KYNMOBI prescribing information (Dosage and Administration)** to lessen or prevent nausea and vomiting? ☐Yes ☐No
2. Please check 1 of the following ICD10 codes:
   ☐R11.2 (Nausea and vomiting) ☐Other _____

PRESCRIBER AUTHORIZATION FOR MONITORING

☐ 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:

(Signature required. No stamps please.)

Date:

☐ Dispense as written.

STEP 3: Complete Patient Information

Patient Information:
Please provide a copy of the patient's facility FACE sheet.

☐ Policyholder same as patient:

Patient Name:

Date of Birth: Sex: ☐ M ☐ F

Language: ☐ English ☐ Spanish ☐ Other

Daytime Phone: Evening Phone:

STEP 4: Prescription Drug Coverage Information

☐ Policyholder same as patient:

Primary Insurance: Policy #:

Group #: Insurance Phone #:

Patient First Name:

Patient Last Name:

☐ No Insurance ☐ Secondary insurance available

STEP 5: List Clinical Diagnosis and Related Information for the KYNMOBI Prescription

Clinical Information:

Diagnosis and ICD10 Code:

1. Is the patient experiencing OFF episodes associated with Parkinson's disease?
   ☐ Yes ☐ No

Please list any allergies:

Please list all other medications that the patient is currently taking:

Note: *$5HT_3$ antagonists are contraindicated with KYNMOBI*

Please attach medication regimen

STEP 6: Facility Education

KYNMOBI Education

1. Has the facility previously received a KYNMOBI in-Service?
   ☐ Yes ☐ No
2. Is the facility requesting a KYNMOBI in-Service?
   ☐ Yes ☐ No

If yes, facility contact name:

Title:

Contact phone number:

Contact email:

Requests for in-Service can be sent to LTCrequest@sunovion.com.

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.

PLEASE FAX COMPLETED FORM TO THE KYNMOBI PHARMACY PROVIDER AT THE TOP OF THE PAGE.