AMPYRA™ Patient Support Services Center Prescription & Service Request Form

Fax completed form to 888-883-3053 Phone: 888-881-1918

1 STEP ONE: Complete Patient and Insurance Information (Please include copies of insurance cards)

First Name: ____________________ Last Name: ____________________ Middle Initial: ____ Sex: ❑ Male ❑ Female DOB: __________________

Address: ____ City: __________________ State: __________ Zip Code: ____________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________ Preferred Number: ____________

Primary Medical Insurance: _______________ Cardholder Name: ___________________ Relationship to Cardholder: ❑ self ❑ spouse ❑ child ❑ other

Group # ______________________________ ID #: _________________________ Phone: ____

Secondary Medical Insurance: ______________ Cardholder Name: ___________________ Relationship to Cardholder: ❑ self ❑ spouse ❑ child ❑ other

Group # ______________________________ ID #: _________________________ Phone: ____

❑ Patient does not have insurance Does this patient have a prescription drug card? ❑ Yes ❑ No Prescription Drug Insurer: ____________________

BIN #: ________________ ID #: _________________________ Group #: ______________________________ Phone: ______________________

ICD-9 code: ❑ 340 Multiple Sclerosis Type: ❑ relapsing-remitting ❑ primary progressive ❑ secondary progressive ❑ progressive relapsing

❑ Other (please specify): ____

2 STEP TWO: Read and Sign Patient Authorization

By signing this Authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to AMPYRA Patient Support Services Center, on behalf of Acorda Therapeutics, Inc., and its representatives, agents, and contractors (collectively "Acorda") for the following purposes: (1) to establish my eligibility for benefits; (2) to communicate with my health care providers and me about my medical care; (3) to facilitate the provision of products, supplies or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to evaluate the effectiveness of AMPYRA's education programs. I understand that my Personal Health Information disclosed under this authorization may be redisclosed by Acorda and is no longer protected by Federal privacy laws. I understand that my health care providers and insurance company will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be eligible to receive assistance through the AMPYRA Patient Support Services Center. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Acorda Therapeutics, Inc., 9717 Key West Avenue, Rockville, MD 20850, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires ten (10) years from the date signed below.

▶▶ **Patient or Guardian Signature:** ______________________________ **Relationship to Patient:** ____________________ **Date:** ______________

I further authorize the release of information provided in this enrollment form to Acorda for the provision of education, training, and ongoing support on the use of AMPYRA. Acorda may provide me with educational or product-related informational materials. The AMPYRA Patient Support Services Center provider may receive compensation from Acorda for providing such services. I authorize Acorda to contact me with promotional materials related to my treatment, to use and give out my information to send me information or materials related to AMPYRA or any other related products or services in which I might be interested, to contact me occasionally to get me feedback (for market research purposes) about Acorda or the AMPYRA Patient Support Services Center, to operate (and improve the quality of) the AMPYRA Program, or otherwise as required or permitted by law. If I do not wish to receive information related to AMPYRA or any related products or services or to be contacted occasionally for market research purposes, I understand that I may call the AMPYRA Patient Support Services Center's toll-free number, 888-881-1918 at any time.

▶▶ **Patient or Guardian Signature:** ______________________________ **Relationship to Patient:** ____________________ **Date:** ______________

3 STEP THREE: Complete Prescriber Information

Prescriber's Name (Last, First): ____ Specialty: ______________________

Practice Name: ______________________________ Phone: ______________________ Fax: ______________________

Address: ______________________________ City: ______________________ State: ________ Zip Code: ____________

Email: ____ NPI #: ______________________

Office Contact: ____ Contact Phone: ______________________

4 STEP FOUR Complete and sign Rx Information

Rx: **AMPYRA (dalfampridine) Extended Release Tablets, 10 mg** *Dispense as Written*

Sig: ____ Dispense: ____________ tablets Refills: ______________

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

▶▶ **Prescriber's Signature:** ____ **Date:** ______________

5 STEP FIVE: Complete & Sign Physician Authorization

I authorize the AMPYRA Patient Support Services Center administered by TheraCom to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with the AMPYRA Patient Support Services Center to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes. TheraCom may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, TheraCom is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

▶▶ **Prescriber's Signature:** ______________________ **Date:** ____________ **TheraCom Signature:** ______________________ **Date:** ____________

Please Fax to: 888-883-3053 when completed.