

# Prescription & Enrollment Form

PLEASE PRINT

PLEASE SELECT A SPECIALTY PHARMACY PROVIDER:

**PHARMA CARE**  
Phone: (800) 238-7828  
Fax: (877) 287-7226

**ACCREDITO**  
Nova Factor  
Phone: (866) 898-0104  
Fax: (866) 898-0069

<p>Step 1: Complete Physician Information</p>	<p><b>Prescriber Name:</b> _____</p> <p>Office Contact: _____</p> <p>Practice Name: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>DEA #: _____ State License #: _____</p> <p>Nat'l Provider ID #: _____ Medicaid Provider # (if applicable): _____</p>
<p>Step 2: Check (✓) Boxes for Start-up Rx &amp; Titration Orders</p> <p>OR</p> <p>Check (✓) Boxes for Ongoing Rx</p>	<p><b>Rx: APOKYN® (apomorphine hydrochloride injection) 3 mL Cartridges</b> Administer doses as directed.</p> <p><input type="checkbox"/> Initial Prescription= one titration kit (Sig: Use as directed) includes one box of five 3 mL cartridges, one APOKYN® Pen Pak (includes one pen device and six pen needles), one box of 100 BD Ultra-Fine™ pen needles 29G x ½ inch, and one 1.5 quart sharps container.</p> <p><b>Rx: Trimethobenzamide HCl 300 mg Capsules</b></p> <p><input type="checkbox"/> Take one capsule by mouth three times daily for nausea. Begin taking three days prior to initial APOKYN® dose. Quantity: 90</p> <p style="text-align: center;"><b>OFFICE WILL BE CONTACTED FOR MAINTENANCE DOSE AFTER PATIENT'S INITIATION APPOINTMENT.</b></p>
<p>Check (✓) Boxes for Ongoing Rx</p>	<p><input type="checkbox"/> <b>APOKYN® (apomorphine hydrochloride injection) 3 mL Cartridges Maintenance Prescription</b> _____ mL/dose, do not exceed _____ doses per day. Dispense _____ doses per fill. Refills _____</p> <p><input type="checkbox"/> BD Ultra-Fine™ pen needles 29G x ½ inch. Quantity: Box of 100 Refills _____</p> <p><input type="checkbox"/> <b>Trimethobenzamide HCl 300 mg Capsules</b>, take one capsule by mouth three times daily for nausea. Quantity: 90 Refills _____</p> <p><input type="checkbox"/> APOKYN® Pen Pak (includes one pen device and six pen needles)</p>
<p>Step 3: Schedule in home patient education/ titration</p>	<p><b>APOKYN® In Home Titration, Education, &amp; Training Services</b></p> <p><input type="checkbox"/> Schedule patient for <b>initial</b> in-home education and training</p> <p><input type="checkbox"/> Schedule patient for <b>additional</b> in-home education and training</p> <p><input type="checkbox"/> Schedule patient for dose escalation to: _____ mL/dose</p> <p>For dose escalation hold oral PD drugs <b>1 dose prior</b> to titration home visit</p> <p><b>Specialty Pharmacy Provider please fax to 877-273-4941</b></p>

<p>Step 4: Complete Patient Information</p>	<p><b>Patient Name</b></p> <p>Date of Birth _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____</p> <p>Last 4 digits of Social Security #: XXX-XX-</p> <p>Daytime Phone _____ Evening Phone _____</p> <p>Alternate Contact _____ Phone Number _____</p> <p>Address (No P.O. Box) _____</p> <p>City _____ ST _____ Zip _____</p> <p><b>*Starter Rx will be shipped to this address*</b></p>
<p>Step 5: Complete Insurance Information (PLEASE FAX A COPY OF INSURANCE CARD(S) FRONT AND BACK.)</p>	<p><b>Insurance Co.</b></p> <p>Insurance Phone # _____</p> <p>Policy Number _____ Group Number _____</p> <p>Policy Holder's Name _____</p> <p>Subscriber # _____</p> <p>Employer (if known) _____</p> <p>Relationship to Patient _____</p> <p>Is there a prescription card? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Carrier _____</p> <p>Policy Number _____ Group Number _____</p>
<p>Complete Secondary Insurance Information (if applicable)</p>	<p><b>Secondary Insurance Co.</b></p> <p>Insurance Phone _____</p> <p>Policy Number _____ Group Number _____</p> <p>Policy Holder's Name _____</p> <p>Subscriber # _____</p> <p>Employer (if known) _____</p> <p>Relationship to Patient _____</p> <p>Is there a prescription card? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Carrier _____</p> <p>Policy Number _____ Group Number _____</p>
<p>Step 6: Sign Statement of Medical Necessity</p>	<p><b>I certify APOKYN® therapy is necessary for this patient.</b></p> <p>Prescriber's Signature _____ Date _____</p> <p style="text-align: center;"><i>(Signature required. No stamps please.) (Dispense as written.)</i></p>

**Fax: 1.866.898.0069**

Thank you for choosing Accredo Nova Factor as your  
Special Care Pharmacy for Apokyn.

