AMPYRA® Patient Support Services Center

Prescription & Service Request Form

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

Please complete all fields to avoid any delays in processing.

ampyra® (dalfampridine) 10 mg EXTENDED RELEASE TABLETS

PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____ Sex: ❑ M ❑ F

Email:_____ Last 4 Digits of SSN:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

Preferred Phone:_____ Alternate Phone:_____

INSURANCE INFORMATION

Prescription Drug Insurer:_____ BIN #:_____ ID#:_____

Group #:_____ Phone:_____ Name of Specialty Pharmacy for other medication(s):_____

Primary Medical Insurance:_____ Cardholder Name:_____

Relationship to Cardholder: ❑ self ❑ spouse ❑ child ❑ other ID#:_____ Group #:_____ Phone:_____

Secondary Medical Insurance:_____ Cardholder Name:_____

Relationship to Cardholder: ❑ self ❑ spouse ❑ child ❑ other ID#:_____ Group #:_____ Phone:_____

❑ Patient does not have insurance

PATIENT AUTHORIZATION

I have read and agree to the attached **Patient Authorization Section A (Signature Required).**

X _____

Patient Signature *Date*

Initial Here ☐ The signature to the left also denotes that I authorize Ampyra Patient Support Services to leave information regarding my Ampyra prescription, insurance coverage, and Speciality Pharmacy Provider on my answering machine or voicemail.

Initial Here ☐ The signature to the left also denotes that I have read and agree to the attached Patient **Marketing Consent Section B** (participation optional).

FOR OFFICE USE ONLY

PRESCRIBER INFORMATION

Prescriber's Name:_____ Specialty: Neurology ❑ Yes ❑ No Other:_____

Practice Name:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

Office Contact Name:_____ Contact Phone:_____ NPI #:_____

☐ I authorize Ampyra Patient Support Services to contact patient directly to obtain patient signature.

PRESCRIPTION

Rx: AMPYRA (dalfampridine) Extended Release Tablets, 10 mg

Sig: **1 tab po q12h**

Other:_____

Dispense: ❑ 60 tablets (30 day supply) Refills:_____

❑ 180 tablets (90 day supply) Refills:_____

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.I authorize the Lash Group, Inc. ("Lash") as the operator of the AMPYRA Patient Support Services Center on behalf of Acorda Therapeutics, Inc. ("Acorda") to be my designated agent and to act for me, a covered entity, as my business associate (as those terms are 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. I authorize Lash to contact the patient to report coverage information and to inform them about the financial assistance programs offered by Acorda. Lash 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, Lash is required to comply with, and by my signature hereto and that of Lash, each agrees to comply with the terms of the Business Associate Agreement ("BAA") at www.lashgroup.com/BAA and Lash will safeguard any protected health information that it obtains form me or on my behalf, and will use and disclose this information only for the purposes specified in BAA or as otherwise permitted by law.

X _____

Prescriber Signature *Date*

X _____

Lash Group Signature *Date*

Indicate ICD-9 Code:

❑ 340 Multiple Sclerosis

❑ Other:_____

CLINICAL INFORMATION *(recommended)*

❑ Patient is ambulatory Baseline (T25FW _____ Seconds) Date completed:_____

Patient's EDSS Score:_____ Current Disease Modifying Therapy for MS:_____

History of Seizure: ❑ Yes ❑ No

Moderate or Severe Renal Impairment: (CrCl <50 mL/min): ❑ Yes ❑ No Serum Creatinine:_____ mg/dL

Estimated CrCl:_____mL/min. CrCl can be estimated using the following equation (multiply by 0.85 for women): CrCl = [(140-age) x weight (kg)]/[SerumCr (mg/dl) x 72]

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Please read the following statements carefully, then sign and date where indicated on the previous page.

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A. PATIENT AUTHORIZATION

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers (collectively, my "Providers") to disclose my personal health information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription (collectively, "Personal Health Information"), to Acorda Therapeutics, Inc. ("Acorda") and its representatives, agents, and contractors, including to Acorda's AMPYRA Patient Support Services Center operated by The Lash Group, Inc. on behalf of Acorda (collectively "the Entities") for purposes of (1) the provision of services to me by the AMPYRA Patient Support Services Center; (2) to facilitate the provision of products, supplies or services by Acorda; (3) to register me in any applicable Acorda product registration program; (4) to evaluate the effectiveness of Acorda's AMPYRA education programs and (5) to enroll me in Acorda's First Step Program, patient assistance program, and/or copay mitigation program (if one or more such programs apply to me). I understand that my pharmacy provider(s) will disclose to Acorda and/or its representatives, agents, and subcontractors certain personal health information regarding the dispensing of my Ampyra prescription and that such disclosure will result in remuneration to my pharmacy provider(s). I understand that once my Personal Health Information is disclosed to the Entities under this authorization, it is no longer protected by Federal privacy laws and may be further disclosed by the Entities; however, Acorda agrees to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as permitted or required by law. I understand that I may refuse to sign this authorization. I understand, however, that if I do not sign this authorization, I will not be able 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 before notice of the cancellation is received by my health plans or health care providers. This authorization expires ten (10) years from the date signed below.

B. PATIENT MARKETING CONSENT

I further authorize the release of information provided in this enrollment form to Acorda Therapeutics, Inc. ('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 Lash Group, Inc, which operates the AMPYRA Patient Support Services Center for Acorda, 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 obtain feedback (for market research purposes) about Acorda, AMPYRA, 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.

What You Need to Do to Receive Your AMPYRA® Delivery

AMPYRA Patient Support Services Center will contact you to verify your insurance and co-pay amount. To verify your insurance and co-pay amount, **you must speak to the representative** who calls.

*** These calls may be from unrecognizable 800/888 phone numbers.**

A Specialty Pharmacy will call to arrange your AMPYRA delivery. To receive your AMPYRA, **you must speak to the representative** who calls you to confirm your shipment.

*** These calls may be from unrecognizable 800/888 phone numbers.**

Have questions? Call AMPYRA Patient Support Services toll-free 1-888-881-1918 Monday through Friday, from 8 AM to 8 PM ET.

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