# Trokendi XR Service Request Form

**Fax completed form to Supernus Support at 1-855-998-1515**
**Phone: 1-866-398-0833 ■ www.TrokendiXR.com**

**Trokendi XR®** (topiramate)
extended-release capsules

## STEP 1: Patient Information

Name: _____

Sex: ❑ Male ❑ Female Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____

Parent/Legal Guardian: _____

Phone: _____ Alternate Phone: _____

**Patient Insurance:** Complete the information below or include copies of insurance cards.

Name of Pharmacy Plan: _____ Phone: _____

Rx Bin: _____ Rx PCN: _____

Group #: _____ Plan ID #: _____

**Primary Insurance**

Name of Medical Plan: _____ Phone: _____

Relationship to Cardholder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Cardholder Name: _____ Plan Number: _____

Group Number: _____ ID Number: _____

**Secondary Insurance**

Name of Medical Plan: _____ Phone: _____

Relationship to Cardholder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Cardholder Name: _____ Plan Number: _____

Group Number: _____ ID Number: _____

## STEP 2: Read and Sign Patient Authorization

By signing this Authorization, I authorize my health plans, physicians and pharmacy providers to disclose my personal health information ("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, to The Lash Group, Inc., an AmerisourceBergen Consulting Services Company as administrator of Supernus Support and its representatives, agents, and contractors (collectively "Supernus Support") 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; and (4) to register me in any applicable product registration program required for my treatment. I understand that my Personal Health Information disclosed under this authorization may be redisclosed by Supernus Support and is no longer protected by federal privacy laws. I understand that if I refuse to sign this disclosure, Supernus Support may be unable to determine my eligibility for benefits and will be unable to register me in the applicable product registration program required for my treatment. I understand that I am entitled to a copy of this Authorization. I understand that I may revoke this Authorization at any time by mailing a letter requesting such revocation to the physician to whom I provided such authorization, with a copy to The Lash Group, Inc., 9717 Key West Avenue, Rockville, MD 20850, but that this revocation will not apply to any information already used or disclosed through this Authorization. This Authorization expires ten (10) years from the date signed below. A photocopy of this authorization will be treated in the same manner as the original.

Signature: _____

Relationship to Patient: _____ Date: _____

## STEP 3: Prescriber Information

Prescriber Name: _____

Speciality: ❑ Neurology Other: _____

Prescriber Address: _____

Prescriber Address #2: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Fax: _____ NPI#: _____ Medicaid #: _____

Physician Office Contact: _____ Phone: _____

Physician Email: _____

## STEP 4: Complete RX Information

Diagnosis: _____ ICD-10 Code: _____

Medications Previously Tried and Failed With Reason for Discontinuation:

| Medications | Reason | Date of Discontinuation |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |

Medications Currently Taking:

1. _____ 2. _____

**Trokendi XR® (topiramate) extended-release capsules**

Drug Strength: _____

Quantity Prescribed: _____

Directions for Use: _____

Prescriber Signature: _____ Date: _____ Refills: _____

## Step 5: Prescriber Authorization

I certify that the treatment listed above is and will be medically necessary based on my best professional judgment and that the information provided in this form is complete and accurate to the best of my knowledge. I also certify that I have obtained any legally required written permission of the patient (or the patient's legal representative) for the release of my patient's information here and such other health or personal information to Supernus Support ("Supernus Support") and Supernus Pharmaceuticals, Inc. and/or its representatives or agents (collectively, "Supernus Pharmaceuticals, Inc.") as may be necessary for the patient's participation in Supernus Support and for Supernus Support and Supernus Pharmaceuticals, Inc. to use and disclose such information as necessary to provide reimbursement support and other services to me and my patient in connection with the patient's Trokendi XR therapy. I authorize and appoint Supernus Support and SupernusPharmaceuticals, Inc. to convey on my behalf any prescription information delivered to Supernus Support for Trokendi XR to the dispensing pharmacy chosen by or for the patient. I understand that Supernus Support and Supernus Pharmaceuticals, Inc. will use and disclose this information only in connection with Supernus Support, including but not limited to performing a preliminary verification of my patient's insurance coverage for Trokendi XR and assessing my patient's eligibility for participation in the patient assistance program and as otherwise required or permitted by law. I further certify that (a) any service provided through Supernus Support on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Trokendi XR or any other Supernus Pharmaceuticals, Inc. product or service for anyone, and (b) my decision to prescribe Trokendi XR was based on my determination of medical necessity as set forth herein. I agree that Supernus Support and Supernus Pharmaceuticals, Inc. may contact me for additional information relating to Supernus Support or Trokendi XR, including but not limited via email, fax and telephone. I understand that Supernus Pharmaceuticals, Inc. reserves the right, at any time and without notice, to modify or discontinue Supernus Support. I understand that completing this enrollment form does not ensure that I will obtain insurance coverage or reimbursement for my prescription or that my patient will qualify for the patient assistance program, and that any services provided through Supernus Support are provided for information purposes only and represent no statement, promise or guarantee by Supernus Support or Supernus Pharmaceuticals, Inc. I agree that in no event shall Supernus Pharmaceuticals, Inc. be liable for any damages resulting from or relating to Supernus Support.

Prescriber Signature: _____ Date: _____

**Please fax to 1-855-998-1515**

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