AZURITY
PHARMACEUTICALS, INC.

ZONISADE® (zonisamide oral suspension) 100 mg/5 mL
Patient Enrollment Form and Prescription

Patient Information

First Name:	Last Name:		Middle Initial:
Primary Contact:	Relationship:		Language Preference:
Date of Birth:	Age:	Gender:	
Address:		City, State, Zip:	
Phone (please check preferred): ☐Home ( ) -	☐Work ( ) -	☐Mobile ( ) -	
Best time to call: ☐AM ☐PM ☐Okay to leave messages			

Insurance Information (if you are attaching copies, you do not need to complete this section.)

☐Check if you are attaching a copy of the patient's insurance card(s). ☐Patient does not have insurance

Prescription Drug Card: ☐YES ☐NO	Prescription Drug Insurer:		BIN#
ID#	Group#		Phone:
Primary Insurance:	Cardholder:	ID#	Group#
Phone:		Relationship to cardholder:	
Secondary Insurance:	Cardholder:	ID#	Group#
Phone:		Relationship to cardholder:	

Prescriber Information

First Name:	Last Name:		Specialty:
NPI#	DEA#	Tax ID #	Center Name:
Address:		City, State Zip:	
Center Phone #:		Center Fax #:	
Center Contact/Title:	Contact Phone #:		Contact Email:

Diagnosis

Diagnosis:	ICD-10 Code:

Prescription

Please indicate if the patient is currently prescribed ZONISADE® (zonisamide oral suspension) 100 mg/5 mL ☐YES ☐NO

ZONISADE® (zonisamide oral suspension) 100 mg/5 mL >> Quantity:_____ Refills:_____ Patient Weight:_____

☐ Dispense as written Special Instructions:

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the named patient; (2) I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Azurity Pharmaceuticals Inc. ("Azurity") and contractors designated by Azurity for the purpose of verifying the patient's insurance coverage for ZONISADE® (zonisamide oral suspension) providing publicly available information regarding payer coverage and benefits, how to prepare prior authorization requests or coverage determination appeals, or other coverage issues, fulfilling and coordinating delivery of medication, and providing me and my patient with educational and support services associated with ZONISADE® (zonisamide oral suspension); (3) I will not sell or bill any free product received in my office; and (4) I authorize the above prescription to be forwarded to the pharmacy chosen by the named patient.

Prescriber Signature:_____ Date:_____/_____/_____.

PLEASE FAX TO 1 (866) 927-2052

Telephone inquiry – 1 (844) 472-2032

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Patient Authorization

Patient Name: _____ Date of Birth: ____/ ____/ ____

By signing this Authorization, I authorize my healthcare providers, health plans, 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 information about my prescriptions ("Personal Health Information"), to Azurity and its representatives, agents, contractors, and affiliates (collectively, "Azurity") in order for Azurity to provide product support services. I further authorize Azurity to use and disclose my Personal Health Information to third parties, including, but not limited to specialty pharmacies, health plans, insurance companies, and patient assistance programs for such product support services, including, but not limited to, investigating insurance coverage, fulfilling and coordinating delivery of medication and communicating with me by mail, e-mail, or telephone about my medical condition, treatment, care management, and health insurance.

I understand that my Personal Health Information, once disclosed under this authorization, may no longer be protected by federal privacy laws and could be disclosed by Azurity as well as other recipients of the information to others not identified in this Authorization. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment in a health plan, or eligibility for benefits, including my access to therapy, is not conditioned on my signing this Authorization. I understand that I am entitled to a signed copy of this Authorization. I understand that I may cancel this Authorization at any time by notifying Azurity in writing and submitting it by fax to 1-866-927-2052 or by calling 1-844-472-2032. If I cancel, Azurity will stop using or dislosing my information for the purposes listed above, except as required by law or as necessary for the orderly termination. I also understand, however, that any such cancellation will not apply to any information already used or disclosed based on this Authorization prior to receipt of the cancellation by Azurity. This Authorization expires ten (10) years from the date signed below.

Patient or Legal Guardian Signature: _____ Date: ____/ ____/ ____

I, the patient or legal guardian(s), authorize the following individual(s) to act as my representative(s). These individual(s) have my full permission to obtain and disclose personal and medical information about me to Azurity and its agents and contractors.

Patient or Legal Guardian Signature: _____ Date: _____/ _____/

Name of Patient Representative: _____ Relationship: _____

Home Phone: _____ Mobile: _____

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