

Patient Information

Patient Name: _____
First Last

Date of Birth: _____ / _____ / _____
Month Date Year

Prescriber Contact Information

Name: _____

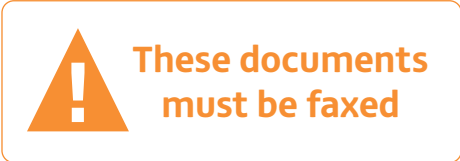
Phone #: _____

Important NOTE to Prescribers
 Help smooth the prescription process and reduce callbacks to your office by providing the required information.

This form cannot be processed unless you submit the minimum documentation. Requirements for coverage, including minimum documentation, may vary by payer. Updates by the prescriber may be needed if patient history changes. Information provided in and with this form may be used to enroll/offer VYALEV at no cost through VYALEV Complete.

MINIMUM MEDICAL DOCUMENTATION THAT MUST BE SUBMITTED IN ATTACHED CHART NOTES

VYALEV coverage consideration for motor fluctuations requires medical records from the last 6 months by a neurologist who prescribes and manages treatment with carbidopa-levodopa. **To ensure processing of this form, fax copies of each of the following records as part of the Chart Notes:**



**Fax these documents to
 1-888-953-2762**

- Fully completed form
- Patient's insurance cards (both front and back)
- Patient's medical documentation
 - Diagnosis of Parkinson's disease
 - Documentation that the patient is levodopa-responsive
 - Motor fluctuations as documented with "off" periods for a minimum of 2.5 hours/day despite current medical therapy

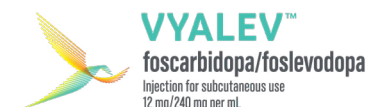
Indication¹

VYALEV is indicated for the treatment of motor fluctuations in adults with advanced Parkinson's disease (PD).

Safety Considerations¹

VYALEV is **contraindicated** in patients who currently take or have taken (within 2 weeks) a nonselective monoamine oxidase [MAO] inhibitor, as concurrent use can cause hypertension. VYALEV may cause **sudden falling asleep** during daily activities and somnolence; **hallucinations/psychosis**; compulsive behavior or **lack of impulse control**; **infusion site reactions and infections**; **withdrawal-emergent hyperpyrexia** and confusion; **dyskinesia**; **cardiovascular ischemic events**; or worsening **glaucoma**.

The **most common adverse reactions** for VYALEV (VYALEV incidence at least 10% and greater than oral carbidopa/levodopa incidence) were infusion/catheter site reactions, infusion/catheter site infections, hallucinations, and dyskinesia.



1. Patient Information

The prescriber and the patient or legally authorized person should fill out section 1 completely before the patient leaves the office.

Patient Name: _____

Date of Birth: _____ / _____ / _____
First / Last / Month / Date / Year

Sex: Male Female

Phone #: _____

Email: _____

Check here if patient is a veteran

Check here if an interpreter is needed

Language: _____

Authorized Caregiver Contact Information:

Name: _____
First Last

Relationship to patient: _____

Phone #: _____

Email: _____

Facility Information:

Patient Resides in a Facility (e.g., nursing home, hospital) Yes No

Name of Facility: _____

Facility Contact Name: _____

Facility Phone #: _____

Marketing Consent: I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, clinical trials, research opportunities and for online targeted advertising, as further described in the **"How We May Use Personal Data," "How We May Disclose Personal Data,"** and **"Cookies and Similar Tracking and Data Collection Technologies"** sections of our **Privacy Notice**. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting **"Your Privacy Choices"** on AbbVie's website.

By enrolling, you may receive your own Nurse Ambassador provided by AbbVie. Ambassadors do not work under the direction of your prescriber or give medical advice. They are trained to direct patients to their prescriber for treatment-related advice, including further referrals.

Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, **visit <https://abbvie.com/PrivacyPatient>**.

Consent to Process My Sensitive Information: Through my submission of the enrollment form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the **"How We May Disclose Personal Data"** section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting **"Your Privacy Choices"** on AbbVie's website.

HIPAA Consent: My signature below certifies that I agree to the HIPAA Authorization on page 4.

Indicate relationship: Patient Authorized Caregiver

Patient Signature: _____ Today's Date: _____ / _____ / _____
Month Date Year

▼ FOR PRESCRIBER USE ONLY ▼

2. Insurance Information

Patient benefits cannot be accessed without **all** current insurance information provided. **Please fax a copy of all insurance cards, front and back (prescription and medical insurance as needed),** with this form to the fax number indicated in the top right corner of this form.

4. Prescriber Information

Prescriber Name: _____

Specialty: _____

Clinic Name: _____

3. Specialty Pharmacy Preference

VYALEV may only be filled at one of the below pharmacies. Patient insurance pharmacy mandates will take precedence for filling pharmacy; however, if no mandate is required by insurance, please select patient's pharmacy preference below:

Acaria Health Accredo CVS No preference

If not selected, no preference would be assumed.

Office Contact Name: _____

Office Contact Phone #: _____

Office Contact Email: _____

Office Fax #: _____

Please see additional **Important Safety Information** on page 5.

Please see full **Prescribing Information** or visit https://www.rxabbvie.com/pdf/vyalev_pi.pdf.



Section 5

FOR PRESCRIBER USE ONLY

FILL OUT ALL SECTIONS BELOW – A, B, & C

5(A). Diagnosis and Prescription Information

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

Patient Address: _____ City/State/ZIP: _____

⚠ Patient Diagnosis (MUST SPECIFY ICD-10 CODE to confirm diagnosis for aPD): G20.A2 G20.B1 G20.B2

No Known Allergies Drug Allergies: _____

Prescriber Name: _____ NPI: _____

Prescriber Address: _____ City/State/ZIP: _____

PUMP Route of administration via pump Phillips-Medisize portable infusion pump and pump carry case

⚠ MUST SELECT either Unprogrammed or Programmed. Please see the "PRESCRIBER ACKNOWLEDGEMENT" below.

Unprogrammed (Prescriber will program) Programmed (Specialty Pharmacy will program) PIN requested (XXXX): _____ (Please remember the PIN requested. PIN must be 4 digits AND cannot be consecutive digits [e.g., 2345] or the same 4 digits [e.g., 2222]. The patient should NOT have visibility or access to the PIN requested on this form.) If seeking a Programmed Pump and no PIN is provided, default will be 0951.

5(B). DOSING

Continuous Infusion Flow Rates Flow rates can be set in increments of 0.01 mL/h with a range of 0.15 mL/hr to 1.25 mL/hr.

If High Rate or Low Rate are left blank, it is assumed that those rates are intended to be the same as the Base Rate.

⚠ MUST SELECT Dosing will be administered over 24 hours or Other _____

Pump Settings: Base Rate (X.XX mL/h) High Rate (Y.YY mL/h) Low Rate (Z.ZZ mL/h)

Patient Dose Settings: _____ mL/h _____ mL/h _____ mL/h

(If neither is selected, 24 hours of continuous delivery will be assumed.)

Optional Dosing Features: Extra Dose and Load Dose If left blank, these doses will be assumed to be 0.00.

• Extra Dose mL (check one): 0.10 0.15 0.20 0.25 0.30

Number of times a day (check one): 2 Other _____

Lockout time: _____ hour(s) _____ minute(s) (Range: 1–24 hours [15 min increments]) (If not selected, 2 extra doses per day will be assumed for dispensing purposes.)

• Loading Dose: Once daily Other _____ mL Increments of 0.1; Range: 0.1 mL to 3.0 mL

Lockout time: _____ hour(s) (Range: 3–8 hours [1 hr increments]) (If not selected, 1 loading dose will be assumed for dispensing purposes.)

VYALEV solution vials: 120 mg foscarbidopa and 2,400 mg foslevodopa per 10 mL (12 mg foscarbidopa and 240 mg foslevodopa per mL). 7 10mL vials per carton.

Minimum # of vials: _____

Days Supply: 28 Refills: 12

Change solution at least once every 24 hours; change during waking hours only

Lockout Time: The minimum amount of time that must elapse between doses before the next dose can be administered. Extra Dose Minimum: 1 hour Loading Dose Minimum: 3 hours

Minimum Vial Count Methodology: See page 4.

5(C). SUPPLIES

Braun Omnifix® Syringe 10 mL Luer Lock

Qty: To be determined by pharmacist Refills: 12 SIG: Change syringe at least every 24 hours or sooner, as indicated by pump

West Vented Vial Adapter™ (Carton size of 28 vial adapters)

Qty: To be determined by pharmacist Refills: 12 SIG: Use one per vial

Neria™ Guard Infusion Set: 6 mm

⚠ Choose cannula length 9 mm

1st Fill Qty: 3 cartons (30 units) Refills: 0 SIG: Change cannula at least once every 3 days or more often as directed by your doctor

(If cannula length is left blank, the default 9 mm cannula will be sent)

Refill Qty: To be determined by pharmacist Refills: 11 SIG: Change cannula at least once every 3 days or more often as directed by your doctor

PATIENT DELIVERY SYSTEM TRAINING OPTION:

I request optional supplemental VYALEV delivery system training according to the USPI, if needed, for this patient by an AbbVie-offered and contracted third-party home health nurse who would provide limited training upon request made by the patient to AbbVie ("HHN Training"). My order requesting this training is valid for up to one year, is subject to the terms and conditions listed in the "PRESCRIBER CONSENT" on page 4, and may be canceled by me at any time.

PRESCRIBER ACKNOWLEDGEMENT: By my signature below, I submit this prescription for the above-named patient and I certify the following:

(1) If the "Programmed" option in Section 5(A) above is selected, I acknowledge and agree that I am responsible for the accuracy of all information necessary for programming the pump, including the dosing settings I have specified in the "Continuous Infusion Flow Rates" subsection of Section 5(B) above, and any additional information or instruction required by the Specialty Pharmacy for pump programming, including prescription changes OR If the "Unprogrammed" option in Section 5(A) above is selected, I acknowledge and agree that I am directly responsible for programming the pump, and for the accuracy of the dosing settings I have specified in the "Continuous Infusion Flow Rates" subsection of Section 5(B) above; and, (2) I confirm that I have read, acknowledge, and agree with the "PRESCRIBER CONSENT" on page 4.

PRESCRIBER SIGNATURE AND DATE - STAMP SIGNATURE NOT ALLOWED

Today's Date:

Today's Date:

Dispense as written/Do not substitute

Month / Date / Year

Substitution permitted/Brand exchange permitted

Month / Date / Year

In states not permitting dual prescriptions or specific prescription requirements, please fax a separate prescription.

Prescriber Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit https://abbv.ie/PrivacyHCP.

Please see additional Important Safety Information on page 5.

Please see full Prescribing Information or visit https://www.rxabbvie.com/pdf/vyalev_pi.pdf.

MINIMUM VIAL COUNT METHODOLOGY: The minimum number of vials is based on the highest continuous infusion rate of the dosage administered over a 24-hour period. It serves as an estimate to assist prescribers to determine the number of vials necessary per 28 days based on calculated doses. This takes into consideration appropriate timing of syringe changes during waking hours (16 hours).²

METHODOLOGY: The calculation for the number of vials needed per 28 days is based on the highest continuous infusion rate (mL/hr) maintained over a 24-hour period with waking hour changes only (assuming a 16-hour waking day). The methodology estimates the total volume of medication required daily, which is then extrapolated with an estimated timing of syringe changes to determine the minimum number of vials needed per 28 days. This approach incorporates real-world infusion practices to inform effective medication supply planning. It is important to note that these calculations are derived from mathematical estimates and not from clinical trial results. The goal of this calculation is to provide a practical estimate for the minimum number of vials needed per 28 days. In clinical trials, syringes were changed on a schedule during waking hours only.²

The maximum recommended daily dosage of VYALEV is 3525 mg of the foslevodopa component (equivalent to approximately 2500 mg levodopa). Prescribing a backup oral carbidopa and levodopa product is recommended in the event that delivery of VYALEV is interrupted, which may result in underdosing.¹

PRESCRIBER CONSENT: I authorize VYALEV Complete to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan, and obtaining patient benefit information and the necessary prior authorization forms when dealing with the Health Plan and Pharmacy Benefits Managers (PBMs), if the Plan or PBM requires such authorization. I understand that a representative from the specialty pharmacy will contact the patient to obtain authorization prior to shipping the prescription. Further, if I checked the PATIENT DELIVERY SYSTEM TRAINING OPTION box at the bottom of page 3, I acknowledge and agree that: (i) HHN Training is optional and offered at no charge for benefit of the patient and is not required for the patient to receive the prescribed product; (ii) HHN Training is limited to education based on the approved product labeling and the prescription as written, physical assistance by the home health nurse with placement of the infusion set if the patient requests assistance and adverse event reporting, but no other services and with no reports provided to me by the nurse; (iii) HHN Training is not eligible for reimbursement and I will not seek reimbursement from the patient or any third party payee for HHN Training; and (iv) at any time, I can separately order and direct a home health nurse of my choosing who would not be associated with the HHN Training, AbbVie or any of its contracted vendors.

HIPAA Authorization

Please read the following, then date and sign where indicated on page 2, section 1.
This page must be included when faxed.

I authorize my health care providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to (i) enroll me in, provide, operate and administer the VYALEV Complete Program ("Program"); (ii) provide me with information concerning the Program; and (iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie. I also understand that my Healthcare Providers/Pharmacies may receive benefits, which may include compensation, for my participation in the Program and the disclosure of my Protected Health Information. I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for health care benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner. I understand that I may cancel this Authorization at any time by making a data subject rights request at <https://abbviemetadata.my.site.com/AbbvieDSRM> or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end my enrollment in the Program. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization.

Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records.

Please see additional **Important Safety Information** on page 5.

Please see full **Prescribing Information** or visit https://www.rxabbvie.com/pdf/vyalev_pi.pdf.



Important Safety Information¹

VYALEV™ (foscarnidopa/foslevodopa) is **contraindicated** in patients who are currently taking or have taken (within 2 weeks) a **nonselective monoamine oxidase (MAO) inhibitor**, as concurrent use can cause hypertension.

Patients treated with levodopa (the active metabolite of VYALEV) have reported **falling asleep while engaged in activities of daily living**, including the operation of motor vehicles, which sometimes resulted in accidents. Although many of these patients reported somnolence while on levodopa, some perceived that they had no warning signs, such as excessive drowsiness, and believed they were alert immediately prior to the event (sleep attack). Some of these events have been reported more than one year after initiation of treatment. For this reason, prescribers should continually assess VYALEV-treated patients for drowsiness or sleepiness. Advise patients about the potential to develop drowsiness with VYALEV and ask about factors that may increase risk of **somnolence**. Consider discontinuing VYALEV in patients who report significant daytime sleepiness or episodes of falling asleep during activities that require active participation. If VYALEV is continued, patients should be advised not to drive and to avoid other potentially dangerous activities that might result in harm if the patient becomes somnolent. There is insufficient information to establish that dose reduction will eliminate episodes of falling asleep while engaged in activities of daily living.

There is an increased risk for **hallucinations and psychosis** in patients taking VYALEV. Hallucinations associated with levodopa may present shortly after the initiation of therapy and may be responsive to dose reduction of VYALEV or other concomitantly administered medications. Patients with a major psychotic disorder should not be treated with VYALEV.

Patients may experience **intense urges** while on VYALEV. Because patients may not recognize these behaviors as abnormal, it is important for prescribers to ask patients or their caregivers specifically about the development of new or increased gambling urges, sexual urges, uncontrolled spending, binge or compulsive eating, or other urges while on VYALEV. Consider reducing the dose or discontinuing VYALEV if a patient develops such urges.

VYALEV can cause **infusion site reactions** and **infections**. Various types of reactions at the infusion site have been reported, including erythema, pain, edema, nodules, warmth, swelling, and others. The most frequent infusion

site infection reported was cellulitis. If an infection is suspected at the infusion site, the cannula should be removed. In such a case, either a new cannula should be placed at a new infusion site or, in the event of a prolonged interruption, prescribe an oral carbidopa/levodopa product until the patient is able to resume VYALEV.

Withdrawal-emergent hyperpyrexia and confusion, a symptom complex that resembles neuroleptic malignant syndrome (characterized by elevated temperature, muscular rigidity, altered consciousness, and autonomic instability), with no other obvious etiology, has been reported in association with rapid dose reduction, withdrawal, or change in dopaminergic therapy. Avoid sudden discontinuation or rapid dose reduction of VYALEV.

VYALEV may cause or exacerbate **dyskinesias**, which may require a dose reduction of VYALEV or other medicines used to treat Parkinson's disease.

Myocardial infarction and arrhythmia were reported in patients taking carbidopa/levodopa (the active metabolites of VYALEV). Ask patients about symptoms of ischemic heart disease and arrhythmia, especially those with a history of myocardial infarction or cardiac arrhythmias.

Monitor patients with **glaucoma** after starting VYALEV as it may cause increased intraocular pressure.

Drug Interactions: The use of **nonselective MAO inhibitors** is contraindicated. **Selective MAO-B inhibitors** may be associated with orthostatic hypotension. Concurrent administration with **antihypertensives** can cause symptomatic postural hypotension, which may require a dose adjustment of the antihypertensive. Coadministration with **dopamine D2 antagonists or isoniazid may reduce the effectiveness of VYALEV**.

The most common adverse reactions for VYALEV that occurred in $\geq 3\%$ of patients, and at least 2% difference from oral immediate-release carbidopa/levodopa, were infusion/catheter site reactions, infusion/catheter site infections, hallucinations, dyskinesia, On and Off phenomenon, balance disorder, constipation, peripheral swelling, agitation, insomnia, psychotic disorder, and dyspnea.

VYALEV (foscarnidopa and foslevodopa) injection for subcutaneous use is available in a 120 mg foscarnidopa and 2,400 mg foslevodopa per 10 mL (12 mg foscarnidopa and 240 mg foslevodopa per mL) solution.

Please see full **Prescribing Information** or visit https://www.rxabbvie.com/pdf/vyalev_pi.pdf.

Reference: 1. VYALEV [package insert]. North Chicago, IL: AbbVie Inc. 2. Data on file. AbbVie Inc.