EPIDIOLEX® (cannabidiol)
Hospital to Home Continuity of Care Program

Epidiolex engage™

The Epidiolex Engage™ Hospital to Home Continuity of Care Program provides a 30 days' supply of EPIDIOLEX at no cost to the patient. This program is intended solely for patients being discharged from an inpatient hospital setting who do not have access to EPIDIOLEX upon discharge. This program should be used in situations where, in the practitioner's judgment, a delay in access to therapy could lead to negative clinical outcomes for a patient. Patients who have a supply of EPIDIOLEX at home are not eligible for the program.

IMPORTANT: ***This form should be completed by the healthcare provider, the patient, or the patient's legal guardian in its entirety*** *and a prescription for a 30 days' supply of EPIDIOLEX should be submitted to the Epidiolex Engage Pharmacy. Once received, EPIDIOLEX should arrive at the patient's address provided in accordance with the chart included on this form. Note: An adult over the age of 18 must be available to sign for the medication.*

SECTION 1: PRESCRIBER INFORMATION

Prescriber Name: _____ Title: _____ Specialty: _____

NPI #: _____ DEA #: _____ State License #: _____

Institution Name: _____ Institution Contact Name: _____

Institution Contact Phone: _____ Fax: _____

Institution Contact Email: _____

Institution Street Address: _____

City: _____ State: _____ ZIP Code: _____

SECTION 2: PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Patient Date of Birth: _____ Gender: ☐ Male ☐ Female Weight: _____ kg

Patient Street Address: _____

City: _____ State: _____ ZIP Code: _____

Legal Guardian First and Last Name: _____

Driver's License #*: _____ State of issuance: _____ Expiration date: _____

Primary Phone: _____ ☐ Home ☐ Mobile ☐ Other Email: _____

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Other

Delivery Address: _____ City/State/ZIP Code: _____

(if delivery street address is different from patient address)

*Required by pharmacy for shipment of product.

Clinical Information:

Date of Hospital Admission: _____ Date of Hospital Discharge (anticipated): _____

Has the patient been administered EPIDIOLEX in the hospital setting? ☐ Y ☐ N

Patient's Outpatient Provider: _____ Follow-up with Outpatient Provider scheduled: ☐ Y ☐ N

Current Medications: _____

Known Allergies: _____ ☐ No Known Allergies

Diagnosis:

The diagnosis designations below are intended to ensure communication of accurate information to the appropriate parties in this application process. **EPIDIOLEX is approved to treat seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex in patients 1 year of age and older.** See accompanying Prescribing Information.

ICD-10 Code: _____

Seizures associated with: ☐ Lennox-Gastaut syndrome ☐ Dravet syndrome ☐ Tuberous sclerosis complex

☐ Other (please specify): _____ **Are patient's seizures refractory in nature?** ☐ Y ☐ N

If choosing "Other" and this medication is being prescribed for a use that is not listed on the FDA-approved label, by signing here, I certify that the Prescriber has determined that EPIDIOLEX is medically necessary and appropriate for this patient and this patient's treatment will be supervised.

Signature: _____ **Date:** _____

Name/Title (if Designated Agent): _____

Patient Full Name: _____ Patient Date of Birth: _____

SECTION 3: HEALTHCARE PROVIDER AUTHORIZATION

As the undersigned Prescriber, or the Prescriber's Designated Agent, I understand any EPIDIOLEX provided at no cost to the patient under the Hospital to Home Continuity of Care Program is a short-term supply and is intended solely for the patient being discharged from an inpatient hospital setting.

I understand that, because of the risk of hepatocellular injury, obtaining serum transaminases (ALT and AST) and total bilirubin levels is recommended in all patients prior to starting treatment with EPIDIOLEX. **Please see full Prescribing Information for safety information, including Contraindications and all Warnings and Precautions.**

Signature: _____ **Date:** _____

Name/Title (if Designated Agent): _____

As the undersigned Prescriber, or the Prescriber's Designated Agent, I authorize the use or disclosure of the patient's health information contained on this enrollment form to the patient's other healthcare providers (including pharmacies and Jazz Pharmaceuticals, Inc.), and their respective agents and contractors, and other designees, that are involved in the patient's treatment, to: (1) contact the patient to obtain any other necessary signatures, consents or information relating to the patient's treatment; and (2) provide other related care coordination services, if necessary. I certify that I have obtained my patient's authorization as required by HIPAA to use and disclose patient's personally identifiable health information (including diagnosis and treatment information) for the purposes permitted under this "Healthcare Provider Authorization" Section. I agree that the patient's providers, pharmacies, and other designees may contact the Prescriber or the Designated Agent, as applicable, for additional information as needed relating to the patient's EPIDIOLEX therapy.

Participation in this program does not guarantee coverage or future access to treatment.

The undersigned certifies that: (1) the Prescriber has prescribed EPIDIOLEX for the identified patient; (2) the Prescriber has determined that EPIDIOLEX is medically necessary for this patient; (3) if the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards; and (4) the information provided on this form is accurate to the best of their knowledge.

Signature: _____ **Date:** _____

Name/Title (if Designated Agent): _____

Follow these steps to submit the patient's prescription to the Epidiolex Engage Pharmacy:

☐ Fax the completed form to 1-855-518-7566

☐ Submit a prescription for a 30 days' supply of EPIDIOLEX, via fax to 1-855-518-7566 or via electronic prescription to the Epidiolex Engage Pharmacy (information below).

Pharmacy	Fax	NCPDP # for eRX TRANSMISSION	ADDRESS LISTED for eRX TRANSMISSION
Epidiolex Engage Pharmacy (PharmaCord)	1-855-518-7566	1836191	PharmaCord 11001 Bluegrass Parkway Suite 200 Louisville, KY 40299

Before submitting this form, please ensure:

☐ This enrollment form is complete with all required information requested and includes the prescriber's signatures and date

☐ A separate prescription for EPIDIOLEX is sent via fax or electronic prescription to the Epidiolex Engage Pharmacy (information above)

Please see accompanying full Prescribing Information.

Day Received	Time Received*	Shipment Day	Receipt Day
Monday	Before 2 PM ET	Monday	Tuesday
	After 2 PM ET	Tuesday	Wednesday
Tuesday	Before 2 PM ET	Tuesday	Wednesday
	After 2 PM ET	Wednesday	Thursday
Wednesday	Before 2 PM ET	Wednesday	Thursday
	After 2 PM ET	Thursday	Friday
Thursday	Before 2 PM ET	Thursday	Friday
	After 2 PM ET	Friday	Monday
Friday	Before 2 PM ET	Friday	Monday
	After 2 PM ET	Monday	Tuesday

*Contact must also be made with patient or legal guardian prior to this time in order to arrange delivery.

Please note, Saturday receipt may be an option if delivery is available in the patient's geography and patient's enrollment is received prior to 2 PM ET on Friday. Holiday hours may differ.

SECTION 4: OPTIONAL HIPAA PATIENT AUTHORIZATION FORM

By signing this HIPAA Patient Authorization Form ("Authorization"), I hereby request and authorize my physicians, my pharmacists (including any specialty pharmacy that receives my prescription for EPIDIOLEX) and other healthcare providers ("Providers"), and my health insurers ("Insurers") and their respective agents and contractors, to disclose my protected health information, including but not limited to, information related to my medical condition and treatment (including prescription information), my health insurance coverage and policy number, my name, mailing and e-mail address(es), telephone number, date of birth and Social Security Number ("Protected Health Information" or "PHI"), to Jazz Pharmaceuticals, Inc. and its affiliates, and their respective agents and contractors (collectively, "Jazz Pharmaceuticals") for the following purposes: (i) to contact me, my personal representative(s), guardian(s) or designees, my Providers, Insurers or others I have identified, about my disease or treatment (including EPIDIOLEX); (ii) to provide me with information about support and patient assistance programs and services offered by Jazz Pharmaceuticals; and (iii) to improve or develop products (including EPIDIOLEX), services, programs, or treatment related to my disease; (iv) to de-identify my PHI or combine it with other data for research or analysis. I understand that my pharmacy provider may receive remuneration from Jazz Pharmaceuticals in exchange for sharing information or for my pharmacy providing any support services to me.

I understand that once my PHI has been disclosed to Jazz Pharmaceuticals, my information may be protected by certain state privacy laws but may no longer be protected under federal privacy laws and that my PHI may be subject to re-disclosure. I understand that Jazz Pharmaceuticals will not sell my name, address, e-mail address, or any other information to another party for their own marketing use. I understand that I am not required to agree to this Authorization. If I do not agree, my treatment (including receipt of EPIDIOLEX), payment for my treatment, or eligibility for insurance benefits will not be affected, but I may not receive the other services described above.

I understand that I may cancel this Authorization at any time by: faxing my cancellation to 1-855-518-7566, calling 1-833-GBNGAGE (1-833-426-4243) or mailing a letter to PO Box 5490, Louisville, KY 40255. The Jazz Pharmaceuticals representative shall provide timely notification of my cancellation to the applicable parties. Once they receive and process the notice of cancellation of this Authorization, the applicable parties may no longer share my PHI with Jazz Pharmaceuticals as permitted by this Authorization. However, cancelling this Authorization will not affect any action(s) taken by applicable parties based on this Authorization before receipt of my notice of cancellation. This Authorization will expire in five (5) years from the date this Authorization is signed below, unless a shorter period is required by law of my state of residence. I understand that I have a right to request and to receive a copy of this Authorization.

By signing below, I am indicating that I have read and understood the information set forth in this Authorization.

Patient Name: _____ Date of Birth: _____

Signature of Patient or Guardian, if applicable: _____

Name (if different from patient): _____ Date: _____

Relationship to patient: _____

Email Address: _____

For additional assistance, call us at 1-833-GBNGAGE (1-833-426-4243).
Please see accompanying full Prescribing Information.