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

Jazz Cares®
Making a difference in Patients' lives, one Patient at a time

The JazzCares® 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 JazzCares 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: ______________________

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)

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. Please click for full 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 click for 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 JazzCares® 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 JazzCares Pharmacy (information below

Pharmacy	Fax	NCPDP # for eRX Transmission	Address Listed for eRX Transmission
JazzCares 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 JazzCares Pharmacy (information above)

Please click for 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

I hereby authorize and direct my prescriber(s) and their staff, my health insurer(s) and the specialty pharmacy that will fill my prescription (the "Pharmacy"), to disclose the following information ("Personal Information") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals" or "Jazz") for any Jazz-sponsored patient support programs and activities, including the JazzCares® program:

- Information concerning my treatment with Jazz Pharmaceuticals' products, including relevant diagnoses and prescriptions; and
- Information about my health insurance benefits, including deductibles and out-of-pocket costs.

I understand and authorize Jazz Pharmaceuticals to use and further disclose the Personal Information it receives as a result of this Form for the following purposes:

(i) operating, administering, enrolling me in, and/or continuing my participation in the JazzCares program or any other Jazz-affiliated patient support services and activities related to my condition or treatment; (ii) verifying, investigating, coordinating, and resolving insurance coverage or reimbursement inquiries and payment for Jazz Pharmaceuticals' products; (iii) coordinating my receipt of and payment for Jazz Pharmaceuticals' products; (iv) contacting me about any Jazz-sponsored patient support programs and activities, including the JazzCares program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my Personal Information to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (vi) de-identifying my Personal Information by aggregating it for research purposes; (vii) managing Jazz-sponsored patient support programs and activities, including the JazzCares program, and administrative purposes that support these services and programs.

I understand and authorize Jazz Pharmaceuticals to contact me using the contact information provided to Jazz to enroll me in, operate, and administer any Jazz-sponsored patient support services, including the JazzCares program, through a variety of means including email, postal mail, phone, fax or SMS/text unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below. I understand that the operation and administration of certain of these services and/or programs may require that Jazz contact me by telephone or SMS/text.

I understand Jazz Pharmaceuticals may report back to my prescriber(s) and their staff, my health insurer(s) or the Pharmacy, any Personal Information about me that Jazz Pharmaceuticals may create or receive. I understand that my health insurer(s), Pharmacy, and third-party vendor(s) may receive remuneration (payment) in exchange for disclosing my Personal Information to Jazz Pharmaceuticals (including JazzCares, its affiliates, and vendors who help provide the services) and/or for providing me with support services for the purposes described above.

I understand that after my Personal Information is transmitted to Jazz Pharmaceuticals, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, Jazz Pharmaceuticals will not disclose my Personal Information to a third party that is not related to the patient support programs (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my Personal Information, I understand the receiver may not be subject to HIPAA or other privacy laws and the Personal Information might be re-disclosed by the recipient.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, my health insurer(s) and the Pharmacy, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I can revoke this Form at any time in the future, but if I do so, I may no longer be eligible to participate in Jazz-sponsored patient support programs and activities, including the JazzCares program.

I understand that should I revoke this Form; the revocation will not impact uses and disclosures of my Personal Information that have already occurred in reliance on this Form. This Form will remain valid until termination of enrollment in Jazz-sponsored patient support programs and activities, including the JazzCares program, unless a shorter time is required by state law. I can also revoke it earlier by calling 1-866-997-3688 or sending my request to: Jazz Pharmaceuticals, PO Box 66589, St. Louis, MO 63166-6589. I understand the program may be changed or ended at any time without prior notification. I understand I may request a copy of this Form that is on file with Jazz.

Further information concerning Jazz Pharmaceuticals' privacy practices can be found at https://www.jazzpharma.com/privacy-statement/. If you are a resident of California, a description of the Personal Information collected by Jazz Pharmaceuticals and your rights under the California Consumer Privacy Act can also be found on this website: https://www. jazzpharma.com/privacy-statement/supplemental-notice-for-california-consumers/. I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient Name: ______________________________

Name (if different from patient): ______________________________ Relationship to Patient: ______________

Signature of Patient or Guardian, if Applicable: ______________________________ Date: ______________

For additional assistance, call us at 1-833-426-4243.
Please click for full Prescribing Information

©2023 Jazz Pharmaceuticals, Inc.