PATIENT ASSISTANCE PROGRAM FOR FYCOMPA® (perampanel) CIII — Patient Enrollment Form

PHONE: 1-888-392-6674 Monday through Friday 8 AM – 5 PM ET | FAX: 1-844-633-8444

Please complete all sections in this form and fax to 1-844-633-8444. Incomplete information may cause a delay in processing.

PHYSICIAN INFORMATION

Physician Name: _____ Facility Name: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Office Contact Name: _____ Office Contact Phone: (____) _____-_____

Office Phone: (____) _____-_____ Office Fax: (____) _____-_____ Tax ID#: _____ NPI #: _____

Email: _____ DEA#: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Date of Birth: ____/____/_____ SSN: XXX-XX-_____ Gender: ❒ Male ❒ Female Home Phone: (____) _____-_____ Mobile Phone: (____) _____-_____

Advocate Contact Name: _____ Advocate Contact Phone: (____) _____-_____

Primary Language: _____ Email: _____

PATIENT INSURANCE INFORMATION

❒ Check here if patient is Uninsured

Medical Insurance Name: _____ Insurance Plan Phone: (____) _____-_____

Member ID #: _____ Group #: _____ Policyholder Name: _____

Relationship to Patient: _____ Policyholder Date of Birth: ____/____/_____

Pharmacy Benefit Manager (PBM) Name: _____ PBM Phone: (____) _____-_____

Rx Policy #: _____ Rx Group #: _____ Rx BIN #: _____ Rx PCN #: _____

❒ Patient has multiple Rx plans ❒ Copies of Insurance Cards attached

PATIENT DIAGNOSIS INFORMATION

Diagnosis: _____ ICD-10 Code: _____

MEDICATIONS AVAILABLE

FYCOMPA® (perampanel) CIII: **Tablet:** 2mg 4mg 6mg 8mg 10mg 12mg **Liquid:** 4mL 8mL 12mL 16mL 20mL 24mL

PRESCRIPTION INFORMATION

Product Requested: _____ Strength: _____ Quantity: _____ Refills: _____

Frequency/Directions: _____ SIG: _____ Is this a dosage increase? _____

Allergies: _____ Concurrent Medications: _____

Prescriber: Please attach a separate prescription if this section does not comply with your state's prescription law.

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PHYSICIAN DECLARATION *(NO SIGNATURE STAMPS, PLEASE)*

STOP

The above information is complete and accurate to the best of my knowledge. I have prescribed FYCOMPA based on my independent professional judgment of medical necessity and have taken into account relevant patient safety considerations and the full prescribing information.

STOP

Signature Required for Enrollment ▶ Licensed Practitioner Signature: _____ Date: ___/___/_____

PHYSICIAN AUTHORIZATION FOR HEALTH INFORMATION AND DISCLOSURE

By signing this Authorization, I authorize my healthcare providers, health plans, and pharmacy providers and any other custodian of my healthcare records 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 Catalyst Pharmaceuticals, Inc. and its representatives, agents, contractors, and affiliates (collectively, "Catalyst") in order for Catalyst to provide product support services.

I further authorize Catalyst 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 solely for such Catalyst product support services, including, but not limited to, investigating insurance coverage, providing financial assistance for eligibility for free medication supply, coordinating delivery of medication and communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance.

I understand that my Personal Health Information, once disclosed to third parties under this Authorization, may no longer be protected by state and federal privacy laws and could be disclosed by Catalyst as well as other recipients of the information to others not identified in this Authorization as long as it is used for the purposes outlined herein. I understand that signing this Authorization is voluntary but that if I decide not to sign this Authorization, I will not be eligible to receive these services and benefits for which I may qualify. I understand that I am entitled to a signed copy of this Authorization. I may choose to cancel this Authorization at any time and stop receiving Catalyst services, and, if I choose to cancel, I must do so in writing by sending notice of my cancellation to the following address: Catalyst Pharmaceuticals, Inc, c/o Mercalis, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560. Catalyst personnel will convey the cancellation to all of my healthcare providers, health plans, and pharmacy providers that have previously received the Authorization. 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 Catalyst. This Authorization expires five (5) years from the date signed below.

STOP

Signature Required for Enrollment ▼

STOP

Name of Patient: _____ Signature: _____ Date: _____/_____/_____

Name of Legal Representative: _____ Signature: _____ Date: _____/_____/_____

Relation to Patient: _____

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PATIENT ASSISTANCE PROGRAM ACKNOWLEDGMENT

STOP

I understand that completing this form does not ensure that I will qualify for the FYCOMPA Patient Assistance Program ("PAP"). I represent that the information provided in this enrollment form is complete and accurate. I agree to notify the FYCOMPA Patient Assistance Program if I obtain coverage through another source or if I no longer meet the income criteria for the PAP. I agree that I will not seek reimbursement for or credit from any insurer, health plan, or government program with respect to this prescription. I understand that Catalyst Pharmaceuticals Inc. reserves the right at any time and without notice to me to modify and/or discontinue any or all of the PAP, including modification of eligibility criteria and immediate termination of assistance provided by the PAP. I understand that I may decline to sign this form and decline being considered for the PAP.

STOP

Please Sign Here ▶ Patient or Legal Guardian Signature: _____ Date: ____/____/_____

FYCOMPA® (perampanel) CIII PATIENT ASSISTANCE PROGRAM ADDITIONAL INFORMATION

FYCOMPA PATIENT ASSISTANCE PROGRAM ELIGIBILITY

❒ Patient must be a U.S. Resident

❒ Patients insured by commercial insurance, Medicare, Medicaid, Tricare, VA, or other Federal or State Healthcare plans are not eligible for patient assistance

❒ Financial documentation is required. Acceptable forms of documentation include federal tax return, social security benefit statement, unemployment or disability statement, or one month of paycheck stubs. You may be asked to provide a copy of government issued identification (e.g., driver's license, military ID, passport, etc.)

❒ Household size must be indicated

If the patient is determined eligible for the FYCOMPA Patient Assistance Program, an acceptance letter will be mailed to the patient and faxed to the physician. If the patient is not eligible for the FYCOMPA Patient Assistance Program, a denial letter will be mailed to the patient and faxed to the physician. Enrollment in the FYCOMPA Patient Assistance Program is valid through December 31, 2025 or if commercial coverage becomes available. Completion of the Patient Enrollment Form does not guarantee enrollment into the FYCOMPA Patient Assistance Program. Please notify us of any change in patient insurance status.

PATIENT AUTHORIZATIONS

❒ Be sure the applicant signs and dates BOTH the Patient Authorization for Health Information and Disclosure, and the Patient Assistance Program Acknowledgment

Please write legibly and complete all sections to prevent delays. Forward the completed form to the fax indicated on the enrollment form, or mail to:

FYCOMPA Patient Assistance Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

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