myNEURELIS®
Personalized Support for Patients & Care Partners

Call Us: 1-866-myNEURELIS
(1-866-696-3873)

Fax Us: 1-866-696-7579

Mail Us: P.O. Box 5490
Louisville, KY 40255

REQUESTED SERVICES

☐ Check Drug Coverage ☐ Nurse Education Support ☐ Patient Assistance Program

PATIENT INFORMATION

First Name:	Last Name:	
Date of Birth:	Gender: ☐ Male	☐ Female
Address:		
City:	State:	Zip Code:
Phone Number:	Best Time to Call:	
Email Address:		
Preferred Method of Communication:	☐ Phone	☐ Email
Preferred Language: ☐ English ☐ Spanish	☐ Mandarin	☐ Other

PRESCRIBER INFORMATION

Name:	DEA#:	NPI:
Specialty:	SLN#:	SLN Exp Date:
Site Name:	Office Contact Name:	
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

VALTOCO® (DIAZEPAM NASAL SPRAY) PRESCRIPTION INFORMATION

Due to Board of Pharmacy regulations all myNEURELIS prescriptions must be e-scribed to NABP 1836191 (PharmaCord Pharmacy)

VALTOCO Dose (Circle One)	5 mg dose (1 sprayer per dose)	10 mg dose (1 sprayer per dose)	15 mg dose (2 sprayers per dose)	20 mg dose (2 sprayers per dose)

Patient's Weight: kg Directions:

Prescriber Attests: ☐ Patient has epilepsy ☐ Patient has episodes of frequent seizure activity
☐ Daily seizure medications utilized

Current Medications (Please List):

Medication Allergies: ☐Yes ☐No If yes, list all drug allergies:

UNAPPROVED USE WARNING: Please read the FDA-approved label for VALTOCO before prescribing. PRESCRIBER CERTIFICATION: By signing below, I certify that (a) the above therapy is medically necessary, (b) I have a signed copy on file of the necessary authorization from the patient or patient representative to release the above referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Neurelis and its agents and the dispensing pharmacy or other contractors for the purpose of requesting reimbursement assistance, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for Patient Assistance Program (PAP) related to Neurelis, as a break in treatment would negatively impact the patient's therapeutic outcome and (c) I will not attempt to seek reimbursement for any free, or 'not for sale' VALTOCO provided directly to the patient. I request Neurelis, Inc., Neurelis Patient Support Program ("myNEURELIS") and its authorized agents, contractors, service providers and assignees (collectively, "Neurelis PSP") to act as my agent to transmit the prescription described herein to the dispensing pharmacy chosen by the above-named patient. I agree to comply with the program guidelines as established by Neurelis and understand that Neurelis, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. If applying for Patient Assistance Program, I certify that this patient has no medical insurance coverage or VALTOCO coverage for VALTOCO or is otherwise eligible for the PAP and is not eligible for other public health insurance programs. SPECIAL NOTE: Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as New York, please submit a prescription along with this form in compliance with your state statutes and regulations.

Prescriber Signature (Original – Stamps NOT ACCEPTED) **Date**

PATIENT INFORMATION		
Full Name:	Date of Birth:	
GUARDIAN, CARETAKER OR POWER OF ATTORNEY INFORMATION *		
First Name:	Last Name:	
Relationship with Patient:		
Phone Number:	Best Time to Call:	
Email Address:		
Preferred Method of Communication:	☐ Phone	☐ Email
PREFERRED PHARMACY INFORMATION		
Pharmacy Name:	NCPDP:	
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

By signing this authorization: I authorize my healthcare providers, insurance companies, and pharmacies to disclose, in electronic or other form, to Neurelis, Inc., Neurelis Patient Support Program ("myNEURELIS") and its authorized agents, contractors, representatives, service providers and assignees (collectively, "Neurelis PSP"), all my individually identifiable health information, which may include my full name, demographic information, financial information and information related to my medical treatment, and information related the coordination of my treatment or proposed treatment, receipt of VALTOCO, and education related to seizure rescue (collectively, "My Information"), whether in written or verbal form, so that Neurelis PSP may provide services outlined to me and otherwise administer the Neurelis PSP. I understand that when disclosed to Neurelis PSP, My Information may no longer be protected by certain federal privacy rules.

I authorize Neurelis PSP to use and obtain my medical, financial, or provider information to facilitate my participation in the Neurelis PSP, provide services to me, send me information or materials related to or about my VALTOCO treatment or other related services in which I might be interested, and contact me on occasion for feedback to Neurelis about my VALTOCO treatment and the Neurelis PSP, and to operate and improve the quality of Neurelis PSP services.

I further authorize Neurelis PSP services and its agents to access, use and disclose, receive and maintain My Information to help me with my VALTOCO, to help me understand my insurance coverage benefits if any, to refer me to or determine my eligibility for other VALTOCO programs or public programs or coverage to help me with the costs of my VALTOCO treatment. I authorize Neurelis PSP to access, use and disclose My Information to my caregivers that I identify to Neurelis PSP and to contact third parties (including schools and additional healthcare providers) where necessary to assist in seizure treatment through services provided by MyNEURELIS or education about the appropriate use of VALTOCO.

I consent to receive marketing and promotional communications related to epilepsy and products that treat epilepsy and other information from Neurelis and its agents and representatives. My consent is in effect until such time as I provide notice to Neurelis to opt out of such communications by contacting Neurelis at 1-866-myNEURELIS (1-866-696-3873).

If I do not sign this form, I recognize that I will not be eligible to receive assistance through the Neurelis PSP, but that will not otherwise affect my medical treatment or my health insurance coverage. I understand that my healthcare provider(s) and pharmacy and my health plan and insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization. My Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). I may withdraw this authorization by calling the Neurelis PSP at 1-866-696-3873 or writing to Neurelis PSP at P.O. Box 5490, Louisville, KY 40255. If I do withdraw the authorization, it can no longer be relied upon for Neurelis PSP to use and disclose of My Information, but that will not invalidate uses and disclosures already made in reliance on this authorization. If I do not withdraw the authorization sooner, it will remain valid for 10 years (or such lesser time as state law may require). I understand that I am entitled to receive a copy of this authorization.

* By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

X _____ _____

Patient/Authorized Representative Printed Name | **Relationship to Patient ***

X _____ _____

Patient/Authorized Representative Signature | **Date**

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Additional Required Information for Patient Assistance Program Application

PATIENT INFORMATION	
First Name:	Last Name:
Date of Birth:	Last 4 of Social Security Number:

FINANCIAL INFORMATION		
Annual Household Income:		
Number of Total Dependents in the Household:		
Are you a Resident of the United States?	☐ Yes	☐ No

I hereby certify that I am not insured for (or am rendered uninsured through the payer denial of) VALTOCO. To qualify for free VALTOCO, I understand that my adjusted gross income may not be more than the Neurelis set household income guidelines in relation to the Federal Poverty Level. I understand that my income will be validated through Experian based on the information I provided here above. I understand that Neurelis PSP could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of auditing or verifying my income. If requested, I agree to provide information about my finances as reasonably requested and in a timely manner, if so requested. If my income cannot be verified through Experian, Neurelis PSP will request information from me, my employer, my healthcare provider, or my insurance company to verify my financial or insurance information. I understand that any free VALTOCO provided to me through Neurelis PSP is contingent upon my meeting eligibility criteria as defined by Neurelis; and that Neurelis reserves the right to make an independent determination of my financial and medical need.

Neurelis reserves the right at any time, and without notice, to modify or discontinue this program and any assistance provided to me. I represent and certify that I am a legal resident of the United States and verify that the information provided in this enrollment form is current, complete, and accurate. I agree that I, my healthcare provider, my healthcare provider's institution, or any other person, must not seek payment or accept reimbursement from any third party or payer, including any federal healthcare program such as Medicare or Medicaid, or any private or other insurance plan, or from any other person or entity for any free supply of VALTOCO supplied under this program, regardless of whether a payer subsequently determines that it will cover the VALTOCO. I agree to be responsible for notifying Neurelis VALTOCO if (i) I obtain coverage through another source (federal, state, or private program), (ii) I no longer meet the income criteria for the program, or (iii) I find any errors in my application.

* By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

X _____ _____

Patient/Authorized Representative Printed Name | **Relationship to Patient ***

X _____ _____

Patient/Authorized Representative Signature | **Date**