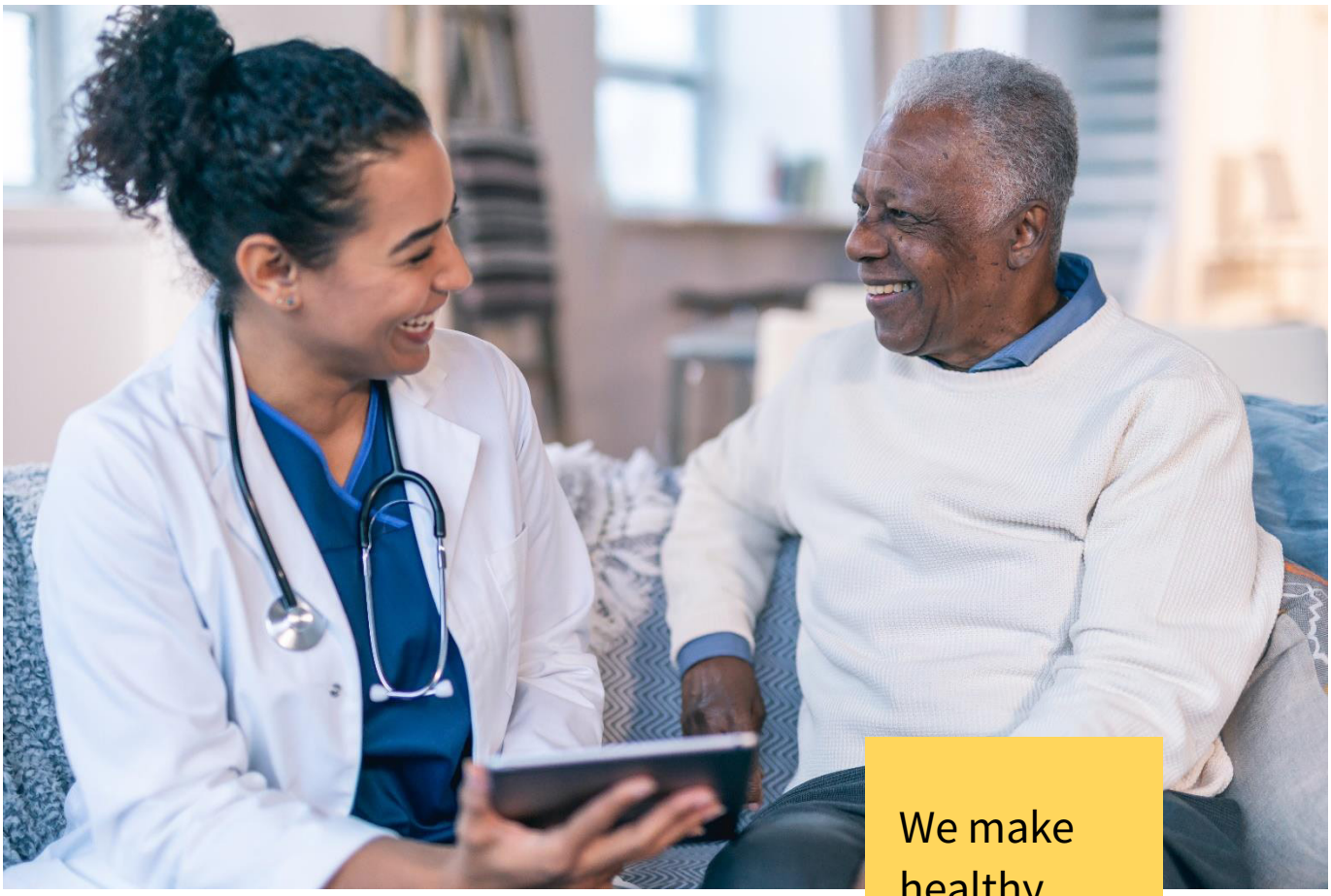
THE AMNEAL PATIENT ASSISTANCE PROGRAM



We make healthy possible®

The Amneal Patient Assistance Program offers eligible individuals the opportunity to apply to receive free medication for up to one year of ONGENTYS® (opicapone) Capsules.

Also, on page 2 you'll find eligibility requirements, instructions and contact information.

amneal®

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

Thank you for your interest in the Amneal Patient Assistance Program. This program is for ONGENTYS® (opicapone) capsules, as listed below. Attached is a copy of the application form.

To be eligible to receive free medicine from Amneal, patients must be residents of US, Puerto Rico or US Virgin Islands, not have affordable coverage for the prescription, have total household income that meets the program eligibility requirements and, if enrolled in a Medicare Part D plan, have an out-of-pocket cost of $200 or greater for the product for a one-month supply.

APPLICATION INSTRUCTIONS FOR PATIENTS - REQUIRED

- Complete all 3 of the follow sections:
  - Patient Information (Section 1)
  - Insurance Information (Section 2)
  - Patient Authorization (Section 3)
- Sign the application.
- If you have a Medicare Part D plan, attach proof of what your household has spent on prescription drugs this year. You will need to provide one of the following: Explanation of Benefits Statement from your Medicare Part D plan provider or a pharmacy printout of year-to-date prescription history.

APPLICATION INSTRUCTIONS FOR PRACTITIONERS - REQUIRED

- Complete Practitioner Information Section 4. Provide phone, fax, and DEA or State License number.
- Complete Prescription Information and Attestation Section 5.
- Have patient complete the Patient Information Sections 1, 2, and 3 and sign the application.
- Attach original valid prescription(s) with physician signature.
- Fax or mail the application, financial documentation, proof of prescription spend (if applicable) and prescription to:

Amneal Patient Assistance Program
PO Box 220586
Charlotte, NC 28222
Phone 1-877-764-9021 Fax 1-877-764-9022

If approved, patients are eligible to receive free medication for up to one year. Medications will be shipped to the patient's home. The Amneal Patient Assistance Program will send an application for renewal when a patient's enrollment is due to expire.

Please call 1-877-764-9021 for questions regarding this program or application.
Monday through Friday, 8:00 am to 5:00 pm CST

THE FOLLOWING MEDICATION ARE AVAILABLE THROUGH THE AMNEAL PATIENT ASSISTANCE PROGRAM

*If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form.

ONGENTYS® (opicapone) Capsules in the following strengths (available in a 30, 60, or 90 day supply)
ONGENTYS® 25 mg
ONGENTYS® 50 mg

SECTION 1 - PATIENT INFORMATION: (REQUIRED-PLEASE PRINT CLEARLY)

NOTE: UPON APPROVAL, MEDICATION WILL BE SHIPPED TO THE PATIENT'S ADDRESS

Last Name, First Name

Gender:

Patient Date of Birth:

Phone Number:

U.S. Resident:

☐ Yes ☐ No

Street Address/Shipping Address:

Medicare Number or SSN:

City:

Number of people in household (including self):

1 2 3 4 5 6 7

State:

Zip Code:

SECTION 2 - PATIENT INSURANCE INFORMATION (REQUIRED)

Do you have a State Patient Assistance Program? ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No

Do you have Medicare A? ☐ Yes ☐ No

Do you have Medicare B? ☐ Yes ☐ No

Do you have Medicare D? ☐ Yes ☐ No

(If yes, please attach current years proof of Out-of Pocket Prescription costs)

Do you have prescription drug coverage? ☐ Yes ☐ No

(If yes, please attach a copy of your insurance card front and back.)

Plan Name:

Phone Number:

Group Number:

Policy Number:

Bin Number:

SECTION 3 - PATIENT AUTHORIZATION FOR USE AND DISCLOSURE (REQUIRED)

By signing below, I authorize my healthcare provider(s) and health insurer(s) to disclose personal health information about me related to my treatment or potential treatment with ONGENTYS® (opicapone Capsules ("My Information") Amneal Pharmaceuticals LLC's patient assistance program service providers and authorized agents (collectively, the "Assistance Group") for purposes of my enrollment and participation in the Amneal Patient Assistance Program (the "Program"). In turn, I authorize the Assistance Group to use and to disclose My Information to my healthcare provider(s) and health insurer(s), and to the Centers for Medicare and Medicaid Services ("CMS"), as deemed necessary to verify the accuracy and completeness of this Program application, and to administer and provide services available through the Program. I understand that when My Information is disclosed to the Assistance Group, it may be subject to re- disclosure and no longer protected by federal privacy, law, but that the Assistance Group intends to use and disclose My Information only as described in this Authorization.

I understand that I may decline to sign this form and that will not affect the way my health care providers or insurer(s) will provide me with their respective services, although I will then be ineligible to participate in the Program. I also understand that I may cancel this Authorization at any time by sending a notice of cancellation to the Assistance Group at: Amneal Patient Assistance Program, PO BOX 220586 Charlotte, NC 28222 (and that any such cancellation will not apply to uses and disclosures made in reliance on the Authorization prior to the Assistance Group's receipt of the notice of cancellation). If I do not cancel the Authorization, it will remain valid for the duration of the period I am enrolled in the Program, or such lesser period as may be required by applicable state law.

I am entitled to receive a copy of this Authorization once it is signed below.

Signature Date

☐ I am the patient ☐ I am a legally authorized representative (complete fields below if checked)

Representative Name:

Relationship to Patient:

☐ Text me about Amneal Patient Assistance Program information. By checking this box, I consent to receive text messages after enrollment into the Amneal Patient Assistance Program. For each program service, I will receive a welcome text asking me to reply CONFIRM to opt-in. Message and data rates may apply; the number of messages varies based on program use but is up to 10 texts per month. Reply STOP to cancel. Privacy policy and full Terms are available at https://amneal.com/internet-privacy-policy/ and https://amneal.com/about/responsibility/patient-assistance-programs/smstc. If this box is NOT checked, you will NOT receive text messages from the Amneal Patient Assistance Program.

PATIENT INFORMED CONSENT TO TERMS AND CONDITIONS OF PATIENT ASSISTANCE PROGRAM

I represent that the information provided in this qualification form is complete and accurate. I agree to notify and shall be responsible for notifying the Program Administrator for the Amneal Patient Assistance Program ("Program") if I obtain coverage through another source or if I no longer meet the income criteria for the Program.

I authorize the Program and its administrators to obtain a consumer report on me. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from the program. Upon request, the Program will provide me the name and address of the consumer reporting agency that provides the consumer report.

I understand that completing this form does not ensure that I will qualify for the Program. I understand that Amneal Pharmaceuticals LLC reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria and immediate termination of assistance provided by the Program.

Signature Date

☐ I am the patient ☐ I am a legally authorized representative (complete fields below if checked)

Representative Name:

Relationship to Patient:

SECTION 4 - PRACTITIONER INFORMATION: (PLEASE PRINT CLEARLY)

Last Name, First Name

Office Contact Person

Office Street Address City State Zip

Phone Number

Fax Number

State License # (or DEA#, if required)

SECTION 5 - ONGENTYS PRESCRIPTION INFORMATION AND ATTESTATION

*Prescriber signature must be the same as the prescriber name above.

Patient Name:	Patient Date of Birth:

Medication and Strength:

Directions:

Quantity:	Refills:

Diagnosis ICD-10

- ☐ G20 Parkinson's Disease
- ☐ G21.2 Secondary Parkinson's due to other external agents
- ☐ G21.3 Postencephalitic parkinsonism
- ☐ Other _____

No Other Medications (check here) ☐
Other Current Medications:

No Known Drug Allergies (check here) ☐
Known Drug Allergies:

Patient Weight:	Patient Height:

By signing below, I verify that the information provided in this enrollment form is complete and accurate to the best of my knowledge. I understand that Amneal Pharmaceuticals LLC reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through Amneal Patient Assistance Program. Finally, I authorize Amneal Pharmaceuticals LLC, its affiliates, representatives and agents to forward the above prescription, by fax or other mode of delivery, to a pharmacy for fulfillment.

Prescriber Signature	Date of Signature
Prescriber State License #	Prescriber Phone Number
Prescriber NPI	Prescriber Fax Number

Prescriber Address

*NY state prescribers must submit prescription on original NY state serialzed prescription blank, via E-script or verbally to the pharmacy pursuant to NY state laws.

Collaborative Prescriber (Printed)

Collaborative Prescriber NPI