FIRDAPSE® (amifampridine) Tablets 10 mg
ENROLLMENT FORM INSTRUCTIONS

Catalyst Pathways™ is a comprehensive Patient Services and Support Program that assists patients throughout their journey to receive delivery of FIRDAPSE®, determine insurance coverage, understand out-of-pocket costs, and access a variety of educational resources. Each patient has a dedicated team of professionals who can help manage patients' unique challenges.

The path to Catalyst Pathways support starts with a completed Enrollment Form.

STEP 1

Complete the Enrollment Form in its entirety.

- ☐ Sections 1 and 2 can be filled out by the Patient or the Prescriber.
- ☐ Sections 3, 4, and 5 should be filled out by the Prescriber.
  - – Section 3 is the prescription (Rx) and should be filled out according to the label on the FIRDAPSE package insert.
  - – If your Patient has never been on amifampridine (or 3,4-DAP) and you want them to participate in the "My FIRDAPSE Therapeutic Dose Program," check the box at the bottom of the prescription in Section 4.
  - – Section 5 includes Medical Criteria that should be filled out by the Prescriber. This section validates the patient's diagnosis of LEMS.
- ☐ Prescriber must sign and date the bottom of page 1.
- ☐ Patient must sign and date the bottom of page 1.

STEP 2

The Patient must sign and date the Patient Authorization of the Enrollment Form (Section 6 on page 2) to be enrolled in Catalyst Pathways.

This step is necessary in order for Catalyst Pathways personnel to communicate with the patient's healthcare provider, insurance company, and financial assistance organizations for access to the Catalyst Pathways programs.

STEP 3

Fax the signed Enrollment Form to Catalyst Pathways at 1-833-422-8260.

If you have any questions, please call us at
1-833-422-8259 7:00 AM – 7:00 PM Central Time

Catalyst PATHWAYS

FIRDAPSE® (amifampridine) Tablets 10 mg
Enrollment Form

Fax#: 1-833-422-8260
Phone#: 1-833-4-CATALYST
(1-833-422-8259)
*Please submit both pages

SECTION 1 - Patient Information

Last Name: ______ First Name: ______ DOB: ______ Sex: ______

Address: ______ City: ______ State: ______ Zip: ______

Phone (Please check preferred): ☐ Home: ( ) ______ ☐ Work: ( ) ______ ☐ Cell: ( ) ______

Caregiver Name: ______ Relation to Patient: ______ Phone #: ( ) ______

Emergency Contact: ______ Phone #: ( ) ______

SECTION 2 - Insurance Information

☐ Patient Uninsured Primary Insurance Co. Name: ______ Phone #: ( ) ______

Policy Holder Name: ______ Policy #: ______ Group #: ______

Prescription Card Name: ______ Phone #: ( ) ______

Policy #: ______ Group #: ______

Secondary Insurance Co. Name: ______ Phone #: ( ) ______

Policy Holder Name: ______ Policy #: ______ Group #: ______

SECTION 3 - Prescriber Information

Prescriber Name: ______ NPI: ______ DEA: ______

Address: ______ Physician Tax ID #: ______

City: ______ State: ______ Zip: ______ State License #: ______

Name of Contact Person: ______ Phone: ( ) ______ Preferred method of communication:

Physician Email: ______ Fax: ( ) ______ ☐ Fax ☐ Phone

SECTION 4 - Rx.

FIRDAPSE (amifampridine) Sig. Take ______ mg. ______ / Daily Quantity ______

Day Supply ______ Refills ______

Special Instructions:

Take your medication exactly as prescribed by your physician.

- The recommended starting dose is 15-30 mg per day in divided doses 3 to 4 times per day.
- Starting dose is 15 mg daily for patients with renal impairment, hepatic impairment and poor metabolizers.
- Dose can be increased 5 mg per day every 3 to 4 days.
- Dose is not to exceed a maximum daily dose of 80 mg per day.
- The maximum single dose is 20 mg.

☐ I agree to enroll my patient in the "My FIRDAPSE Therapeutic Dose Program." My patient is new to 3,4-DAP therapy.

SECTION 5 - Medical Criteria

Primary ICD-10 Code: ______

☐ G70.80 Lambert-Eaton Syndrome, unspecified
☐ G73.10 Lambert-Eaton in Neoplastic Disease
☐ G70.81 Lambert-Eaton Syndrome in Disease classified elsewhere
☐ Other: ______

Previous therapy with 3,4-Diaminopyridine (3,4-DAP) ☐ Yes ☐ No

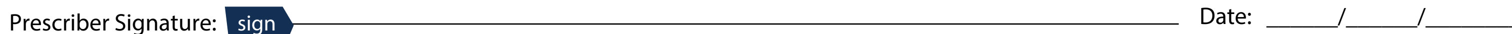
☐ VGCC Antibody Test:
☐ Yes ☐ No ☐ Not Tested

OR

☐ Electrodiagnostic Testing for LEMS:
☐ Yes ☐ No ☐ Not Tested

Allergies: ______

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the named patient; (2) I have received the appropriate permission from the patient (or the patient's Legal Representative) and met any other applicable legal or regulatory requirements such as those imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Catalyst Pharmaceuticals, Inc. (Catalyst) and its agents; (3) I have obtained the patient's authorization to release the above information and such other information as may be required by AnovoRx Manufacturer Services, LLC, as Catalyst's agent, and its employees to assist in obtaining coverage for this drug; and (4) I appoint AnovoRx Manufacturer Services, LLC as my agent for the purpose of conveying this prescription to the appropriate dispensing pharmacy, verifying the patient's insurance coverage for FIRDAPSE (amifampridine) 10 mg tablets, providing information regarding payer coverage and benefits and how to prepare prior authorization requests, coverage determination appeals, or other coverage issues, and providing me and my patient with educational and support services associated with FIRDAPSE (amifampridine) 10 mg tablets.

Prescriber Signature: 

Date: ____/____/______

I have read and agree to the Patient Authorization included on page 2.

Patient/Legal Guardian Signature:

Date: ____/____/______

Signatory's Relationship to Patient:

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SECTION 6 - Patient Authorization

Please refer to our full Privacy Policy at www.catalystpharma.com/privacy-policy/

Print Patient Name: ______________________ Date of Birth: _____ /_____ /________

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 Pathways product support services, including, but not limited to, investigating insurance coverage, providing financial assistance for copay or out-of-pocket payments, 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 join Catalyst Pathways and receive its services and benefits for which I may qualify. I also understand that my treatment, payment, enrollment in a health plan, or eligibility for insurance benefits, including my access to therapy, is not conditioned on my signing this Authorization—only my eligibility for Catalyst Pathways. 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 Pathways services, and, if I choose to cancel, I must do so in writing by sending notice of my cancellation to the following address: Catalyst Pathways, c/o AnovoRx Manufacturer Services, LLC, 1710 N Shelby Oaks Dr., #3, Memphis, TN 38134. Catalyst Pathways 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 ten (10) years from the date signed below.

I agree to my enrollment in the Catalyst Copay Card Program; if confirmed as eligible, I understand that Copay Card information will be sent to my specialty pharmacy, along with my prescription and any assistance with my cost-sharing or copayment for FIRDAPSE will be made in accordance with the Program Terms and Conditions. I understand that Catalyst may provide compensation to my pharmacy provider in exchange for data and/or Catalyst Pathways services that the pharmacy provides to me.

(The following check-boxes describe additional voluntary programs in which you may choose to participate.)

check ☐ I acknowledge that by checking this box, I expressly consent to receive text messages from or on behalf of the Catalyst Pathways Patient Support activities at the mobile number(s) that I provide. Not checking this box will only allow Catalyst Pathways to communicate with me through calls, emails, and the mail.

I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify Catalyst Pathways promptly if any of my numbers change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out from future text messages by responding STOP to any text. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message.

check ☐ I acknowledge that by checking this box, I additionally consent to receive commercial email messages, letters, and/or educational resources from Catalyst Pharmaceuticals. Not checking the box will not affect your ability to receive information, treatment, or services from Catalyst Pathways. If at any time you want to cease receiving such information, please call 1-833-4-CATALYST (1-833-422-8259).

Patient/Legal Guardian Signature: sign ______________________ Date: _____ / _____ /________

I, the patient or legal guardian(s), authorize the following individual(s) to act as my representative(s). These individual(s) have my full permission to obtain and disclose personal and medical information about me to Catalyst and its agents and contractors.

Patient/Legal Guardian Signature: sign ______________________ Date: _____ /_____ /________

Name of Patient Representative: Relationship: ______________________

Home Phone: Mobile: ______________________

PLEASE FAX TO 1-833-422-8260

Telephone Inquiries – 1-833-4-CATALYST / 1-833-422-8259

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MEDICATION GUIDE
FIRDAPSE® (FIR-dapse)
(amifampridine)
tablets, for oral use

Read this Medication Guide before you start taking FIRDAPSE and each time you get a refill. There may be new information. This information does not take the place of talking with your doctor about your medical condition or your treatment.

What is the most important information I should know about FIRDAPSE?
FIRDAPSE can cause seizures.
- You could have a seizure even if you never had a seizure before.
- **Do not** take FIRDAPSE if you have ever had a seizure.

Stop taking FIRDAPSE and call your doctor right away if you have a seizure while taking FIRDAPSE.

What is FIRDAPSE?
FIRDAPSE is a prescription medicine used to treat Lambert-Eaton myasthenic syndrome (LEMS) in adults.
It is not known if FIRDAPSE is safe or effective in children.

Do not take FIRDAPSE if you:
- have ever had a seizure.
- are allergic to amifampridine phosphate, or another aminopyridine.

Before you take FIRDAPSE, tell your doctor about all of your medical conditions. including if you:
- are taking another aminopyridine, such as compounded 3,4-diaminopyridine (3,4-DAP)
- have had a seizure
- have kidney problems
- liver problems
- are pregnant or plan to become pregnant. It is not known if FIRDAPSE will harm your unborn baby. You and your doctor will decide if you should take FIRDAPSE while you are pregnant.
- are breastfeeding or plan to breastfeed. It is not known if FIRDAPSE passes into your breast milk. Talk to your doctor about the best way to feed your baby while taking FIRDAPSE.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins and herbal supplements.

How should I take FIRDAPSE?
- Take FIRDAPSE exactly as your doctor tells you to take it. Do not change your dose of FIRDAPSE.
- Do not take more than 2 tablets of FIRDAPSE at one time or more than 8 tablets in a 24-hour period.
- FIRDAPSE can be taken with or without food.
- If you miss a dose of FIRDAPSE, skip that dose and take your next dose at your next scheduled dose time. Do not double your dose to make up the missed dose.
- Do not take FIRDAPSE together with other medicines known to increase the risk of seizures.
- If you take too much FIRDAPSE, call your doctor or go to the nearest hospital emergency room right away.

What are the possible side effects of FIRDAPSE?
FIRDAPSE may cause serious side effects, including:
- **Seizures. See "What is the most important information I should know about FIRDAPSE?"**
- **Serious allergic reactions, such as anaphylaxis.** FIRDAPSE can cause serious allergic reactions. Stop taking FIRDAPSE and call your doctor right away or get emergency medical help if you have:
  - shortness of breath or trouble breathing
  - swelling of your throat or tongue
  - hives

The most common side effects of FIRDAPSE include:
- tingling around the mouth, tongue, face, fingers, toes, and other body parts

- upper respiratory infection
- stomach pain
- nausea
- diarrhea
- headache
- increased liver enzymes
- back pain
- high blood pressure
- muscle spasms

Tell your doctor if you have any side effect that bothers you or that does not go away.
These are not all the possible side effects of FIRDAPSE.
Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store FIRDAPSE?

- Store FIRDAPSE at 68ºF to 77ºF (20ºC to 25ºC).
- Safely throw away FIRDAPSE that is out of date or no longer needed.

Keep FIRDAPSE and all medicines out of the reach of children.

General Information about the safe and effective use of FIRDAPSE

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use FIRDAPSE for a condition for which it was not prescribed. Do not give FIRDAPSE to other people, even if they have the same symptoms that you have. It may harm them.
If you would like more information, talk to your doctor or pharmacist. You can ask your pharmacist or doctor for information about FIRDAPSE that is written for health professionals.

What are the ingredients in FIRDAPSE?

Active ingredient: amifampridine

Inactive ingredients: calcium stearate, colloidal silicon dioxide, and microcrystalline cellulose.

Distributed by Catalyst Pharmaceuticals, Inc., Coral Gables, FL 33134
For more information, go to www.YourCatalystPathways.com or call 1-833-422-8259
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