

All sections are required for enrollment in JUVMO Complete. Required fields are marked with an asterisk (*). **Print clearly in black ink. Fax all 4 pages (and optional page 5) plus copies of the patient's insurance card(s), front and back, to 1-800-839-7606.**

IMPORTANT NOTE TO PRESCRIBERS

Providing the required information helps smooth the prescription process and reduces callbacks to your office. An incomplete form delays enrollment.



PAGE 1: PRESCRIBER AND PATIENT OR AUTHORIZED CARE PARTNER COMPLETE BEFORE THE PATIENT LEAVES THE OFFICE

1. PATIENT INFORMATION

First Name*		Last Name*		Date of Birth* MONTH / DAY / YEAR		
Sex:*	Primary Phone #*	Mobile Phone # (if different)		Email		
☐ Male						
☐ Female	Address*	City*		State*	Zip*	

AUTHORIZED CARE PARTNER: Required for authorized care partner enrolling on the patient's behalf.

First Name	Last Name	Relationship to Patient	Phone #	Email
------------	-----------	-------------------------	---------	-------

PATIENT CONSENT AND SIGNATURE Signature required.

Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit <https://abbvie.com/PrivacyPatient>.

Consent to Process My Sensitive Information: Through my submission of this enrollment form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "**How We May Disclose Personal Data**" section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting **Your Privacy Choices** on AbbVie's website.

- ☐ **SMS/Text Message Consent:** I consent to receive JUVMO Complete Treatment Support automated and recurring text messages from AbbVie, including services updates and marketing messages, refill reminders, and prescription notifications to the above mobile number. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can reply HELP for help. I can reply STOP to opt out at any time. View privacy notice at <https://privacy.abbvie.com/privacy-policies/us-privacy-policy.html> and mobile T&C at <https://abbvie.com/USMobileTerms>
- ☐ **Marketing Consent:** I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, clinical trials, research opportunities, and for online targeted advertising, as further described in the "**How We May Use Personal Data**," "**How We May Disclose Personal Data**," and "**Cookies and Similar Tracking and Data Collection Technologies**" sections of the AbbVie Privacy Notice. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting Your Privacy Choices on AbbVie's website.

HIPAA Consent: My signature below certifies that I agree to the HIPAA Authorization on page 3.

Patient/Authorized Care Partner Signature:

Today's Date:

☐ Patient ☐ Authorized Care Partner Relationship to Patient: _____ MONTH / DAY / YEAR

2. INSURANCE INFORMATION* Attach all cards, front and back.

☐ Private/commercial ☐ Medicare ☐ Medicaid ☐ VA insurance ☐ Other ☐ Not insured

INDICATION¹

JUVMO is indicated for the treatment of Parkinson's disease in adults.

SAFETY CONSIDERATIONS¹

JUVMO may cause **hypotension/orthostatic hypotension**; compulsive behavior or **problems with impulse control**; **hallucinations and psychotic-like behavior**; or **dyskinesia**. The **most common adverse reactions (≥5%) for JUVMO without levodopa** were nausea, headache, dizziness, fatigue, dysgeusia, vomiting, dry mouth, and anxiety. The **most common adverse reactions (≥5%) for JUVMO with levodopa** were nausea, dyskinesia, dizziness, headache, hallucinations, and orthostatic hypotension.

Please see additional Important Safety Information on **page 4**.

Please see full **Prescribing Information** by visiting https://www.rxabbvie.com/pdf/juvmo_pi.pdf.

ENROLLMENT AND PRESCRIPTION FORM

JPD-072726-A04

Fax: 1-800-839-7606

Call: 1-888-817-4847

Mon-Fri 8AM-8PM ET

All sections are required for enrollment in JUVMO Complete. Required fields are marked with an asterisk (*). **Print clearly in black ink.****PATIENT IDENTIFICATION:** Please complete for reference.

Patient First Name* Patient Last Name* Patient Date of Birth* MONTH / DAY / YEAR

Patient Address* City* State* Zip*

☐ For prescriber use only.

3. DIAGNOSIS AND PRESCRIBER INFORMATION

☐ Parkinson's Disease (PD)* ICD-10 Code* Date of Diagnosis* Drug Allergies (☐ NKA)

4. PRESCRIBER INFORMATION

Prescriber First Name* Prescriber Last Name* Prescriber Title Prescribing License # NPI #* Tax ID #

Prescriber Address* City* State* Zip*

Office Phone #* Office Fax #* Office Contact Name Office Contact Email

Prescriber Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit <https://abbv.ie/PrivacyHCP>

5. PRESCRIPTION INFORMATION *Manual signatures only. Stamps not accepted.*

5A) PRESCRIPTION — New to JUVMO: Sign both boxes. Already taking JUVMO: Submit Maintenance Therapy only (below or section 7B, page 5), unless re-titrating.
Prescriber certification applies to 5A, 5B, and 5C: I certify that the below therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed JUVMO to the previously identified patient and that I provided the patient with a description of the JUVMO Complete patient support program. I authorize JUVMO Complete to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan (if applicable). I further request that JUVMO Complete proceed with benefit verification, pharmacy triage, and service communications as part of JUVMO Complete. I understand in the absence of a separately signed patient/caregiver HIPAA authorization, no Protected Health Information (PHI) will be returned to me from a specialty pharmacy. **For states that do not allow dual prescriptions or that have specific prescription requirements, please include a separate prescription when faxing the enrollment form. Patients taking moderate CYP3A inducers require a separate prescription that follows the dose modification schedule in the Prescribing Information (optional form on page 5, section 7A).**

1. Starting Therapy

☐ JUVMO Titration Pack

Dosing Schedule:

Day 1-4: 0.25 mg Day 13-16: 1 mg
 Day 5-8: 0.5 mg Day 17-20: 1.5 mg
 Day 9-12: 0.75 mg Day 21-24: 2.25 mg
 Day 25-40: 3 mg

Directions:*

Take tablet(s) orally following the daily dosing instructions indicated on the Titration Pack for 40 days

Qty:* 1 pack (40-day supply) Refills:* 0

- ☐ Brand Medically Necessary/Dispense As Written/DAW/Do Not Substitute/May Not Substitute/No Substitution
☐ May Substitute/Product Selection Permitted/Substitution Permissible/ Substitution Permitted

Prescriber Signature*

Date:* ____/____/____

2. Maintenance Therapy

Prescriber note: Dose may be titrated upward in 5 mg increments, approximately every 15 days, up to a maximum dose of 15 mg/day. JUVMO maintenance strengths include 5 mg, 10 mg, and 15 mg tablets. **Each strength requires its own prescription. Additional prescription forms are available on page 5, section 7B (optional) or at JuvmoHCP.com/access.**

Select only one strength per prescription.

☒ JUVMO 5 mg tablets ☐ JUVMO 10 mg tablets ☐ JUVMO 15 mg tablets

Directions:*

☐ Take 1 tablet orally once daily ☐ _____

Qty:* _____ Refills:* _____

- ☐ Brand Medically Necessary/Dispense As Written/DAW/Do Not Substitute/May Not Substitute/No Substitution
☐ May Substitute/Product Selection Permitted/Substitution Permissible/ Substitution Permitted

Prescriber Signature*

Date:* ____/____/____

5B) JUVMO FREE TRIAL PRESCRIPTION

Fill the free JUVMO Titration Pack through an AbbVie-authorized pharmacy?

Available to all eligible patients and filled through an AbbVie-authorized pharmacy. I understand that for Free Trial prescriptions, faxing this form to JUVMO Complete will result in an original copy being simultaneously transmitted to the AbbVie-authorized pharmacy. See Free Trial Terms & Conditions* on the following page for full eligibility requirements and program details.

☐ YES — sign here: _____ ☐ NO — no signature needed. Date: ____/____/____ ☐ May not substitute

5C) JUVMO BRIDGE PROGRAM PRESCRIPTION* For eligible commercially insured patients who experience an insurance delay or denial.

Prescriber Signature:* _____ Date: ____/____/____ ☐ May not substitute

Eligible patients must have (1) commercial insurance, (2) a valid Rx for JUVMO, and (3) experienced a delay or denial in insurance coverage determination. See program Terms and Conditions on the following page. Please complete the full form as well as this section and sign above. Prescription to be filled through an AbbVie-authorized pharmacy. I understand that faxing this form to JUVMO Complete will result in an original copy being simultaneously transmitted to the AbbVie-authorized pharmacy under this section.

6. SPECIALTY PHARMACY PATIENT PREFERENCE

JUVMO may only be filled at one of the below pharmacies. Patient insurance mandates will take precedence for filling pharmacy. However, if no mandate is required by insurance, please select a patient pharmacy below:

☐ AcariaHealth ☐ Accredo ☐ CVS ☐ No preference

FAX ALL 4 PAGES (AND OPTIONAL PAGE 5) PLUS INSURANCE CARDS TO 1-800-839-7606.

Please see Important Safety Information on page 4.

Please see full Prescribing Information by visiting https://www.rxabbvie.com/pdf/juvmo_pi.pdf.

***JUVMO™ Free Trial Program Terms and Conditions:** The JUVMO™ [tavapadon] free trial program provides a single 40-day trial titration supply of JUVMO at no cost to new patients in the U.S., including Puerto Rico, with a valid prescription for JUVMO for an FDA-approved indication who are enrolled in JUVMO Complete. The trial is intended solely to allow new patients not currently taking JUVMO to determine with their healthcare provider whether JUVMO is an appropriate treatment for them. There is no obligation to continue use of JUVMO after the trial has concluded, and this program does not guarantee insurance coverage. Participating patients are limited to one 40-day trial supply of JUVMO. The JUVMO trial supply will be dispensed only through an AbbVie-authorized pharmacy to the patient's home address and may not be sold or further distributed. No claims for payment may be submitted to any third-party insurance plan for product dispensed through the program. AbbVie reserves the right to change or discontinue the trial program at any time without notice. The trial program is not health insurance and is not a discount, coupon, rebate, or financial assistance program. Additional limitations may apply.

***JUVMO™ Bridge Program Eligibility Criteria:** Available to patients in the U.S., including Puerto Rico, aged 63 or younger with commercial insurance coverage and a valid prescription for JUVMO™ (tavapadon) for an FDA-approved indication, including confirmation that established clinical criteria have been met, as well as a denial of insurance coverage based on an initial coverage determination request on file (i.e., prior authorization or formulary exception request) or documentation of delay in resolution of an initial coverage determination request. Continued eligibility for the program requires pursuit of coverage and confirmation of the submission of an appeal of coverage denial every 180 days. The program provides JUVMO at no charge to patients for up to two (2) years or until the patient receives insurance coverage approval, whichever occurs first, and is not contingent upon purchase requirements of any kind. The program is not available to patients receiving prescription reimbursement in whole or in part under Medicare, Medicaid, TRICARE, or any other federal-, state-, or government-funded healthcare programs. Offer subject to change or discontinuation without notice. This offer is not health insurance and participation in the program does not guarantee insurance coverage. No claims for payment may be submitted to any third party for product dispensed through the program. Additional limitations may apply.

JUVMO™ Savings Program Terms and Conditions: 1. This offer is valid only for patients 18 years of age or older and is good for use only with a valid prescription for JUVMO™ at the time the prescription is filled by the pharmacist and dispensed to the patient. 2. This offer is not valid for use by patients receiving prescription reimbursement from Medicare, Medicaid, or any other federal-, state-, or government-funded healthcare programs (including any state pharmaceutical assistance programs) or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. If at any time a participating patient begins receiving prescription drug reimbursement under any federal-, state-, or government-funded healthcare program, the patient will no longer be eligible for the program and must cease participation. This offer is not valid for cash-paying patients. 3. Eligible commercially insured patients may pay as little as \$0 per monthly prescription fill. Patient out-of-pocket expense will vary; check with pharmacist for copay discount. Restrictions, including monthly, quarterly, and/or annual maximums, may apply. 4. Subject to all other terms and conditions, a commercially insured patient whose plan covers JUVMO™ may receive up to a maximum annual benefit of \$12,500 per calendar year, solely for the patient's benefit, under this program. 5. Patients may not seek reimbursement for value received under this program from any third-party payers. 6. AbbVie reserves the right to rescind, revoke, or amend this offer without notice. 7. Offer good only in the U.S., including Puerto Rico, at participating pharmacies. Patients residing in or receiving treatment in certain states may not be eligible to participate in this program. 8. Void if prohibited by law, taxed, or restricted. 9. This card is not transferable. The selling, purchasing, trading, or counterfeiting of this card is prohibited by law. 10. This card has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. 11. This offer is not health insurance. 12. **By redeeming this offer, you acknowledge that you are an eligible commercially insured patient and that you understand and agree to comply with the above terms and conditions.**

For questions about the JUVMO™ Savings Program, please call 1-833-440-0515.

To learn about AbbVie's privacy practices and your privacy choices, visit <https://abbv.ie/corpprivacy>.

HIPAA Authorization

This page must be included when faxed. I authorize my health care providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to (i) enroll me in, provide, operate and administer the JUVMO Complete Program ("Program"); (ii) provide me with information concerning the Program; and (iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie. I also understand that my Healthcare Providers/Pharmacies may receive benefits, which may include compensation, for my participation in the Program and the disclosure of my Protected Health Information. I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for health care benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, AbbVie will not receive updates on my pharmacy shipments and automatically share that information with my Healthcare Providers to allow my Healthcare Providers to have a clear picture of my treatment status and follow up as needed. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner. I understand that I may cancel this Authorization at any time by making a data subject rights request at <https://www.abbvie.com/privacy-inquiry.html> or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end the automatic pharmacy shipment information sharing to AbbVie and my Healthcare Providers. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization. Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records.

INDICATION¹

JUVMO is indicated for the treatment of Parkinson's disease in adults.

IMPORTANT SAFETY INFORMATION¹

Warnings and Precautions

Hypotension/Orthostatic Hypotension: Patients with Parkinson's disease (PD) may have an impaired capacity to respond to an orthostatic challenge. In clinical studies and clinical experience, dopaminergic medications appear to impair the systemic regulation of blood pressure, resulting in hypotension and/or orthostatic hypotension, especially during dose escalation. Patients with PD treated with JUVMO (tavapadon) should be monitored for signs and symptoms of hypotension/orthostatic hypotension, especially during dose escalation, and should be informed of this risk.

Impulse Control/Compulsive Behaviors: Patients may experience intense urges while on JUVMO. Because patients may not recognize these behaviors as abnormal, it is important for prescribers to ask patients or their caregivers specifically about the development of new or increased gambling urges, sexual urges, uncontrolled spending, binge or compulsive eating, or other urges while on JUVMO. Consider reducing the dose or discontinuing JUVMO if a patient develops such urges.

Hallucinations and Psychotic-like Behavior: Medications for the treatment of PD, including JUVMO, can have effects on thinking and behavior. Age appears to increase the risk of hallucinations in patients taking JUVMO. The risk of hallucination may be increased when JUVMO is co-administered with strong CYP3A inhibitors during the maintenance phase. Consider the risks and benefits prior to initiating treatment with JUVMO in patients with a major psychotic disorder because of the risk of exacerbating psychosis. Consider stopping JUVMO if hallucinations or psychotic-like behaviors occur.

Dyskinesia: JUVMO may cause or exacerbate pre-existing dyskinesia. Consider decreasing the dosage of JUVMO or other dopaminergic medications if dyskinesia occurs.

Adverse Reactions

The most common adverse reactions (≥5%) for JUVMO without levodopa were nausea, headache, dizziness, fatigue, dysgeusia, vomiting, dry mouth, and anxiety.

The most common adverse reactions (≥5%) for JUVMO with levodopa were nausea, dyskinesia, dizziness, headache, hallucinations, and orthostatic hypotension.

Drug Interactions

Strong CYP3A Inducers: Avoid use with JUVMO. **Strong and moderate CYP3A inhibitors:** avoid use with JUVMO during titration; JUVMO dosage modification is recommended during maintenance. **Moderate CYP3A Inducers:** JUVMO dosage modification is recommended during titration and maintenance. **Consult the full Prescribing Information for JUVMO** for more information on drug interactions and recommended dosage modifications.

Dosage Forms and Strengths

JUVMO is available as 5 mg, 10 mg, and 15 mg tablets, as well as 0.25 mg and 1 mg tablets contained in a Titration Pack.

Please see accompanying full [Prescribing Information](https://www.rxabbvie.com/pdf/juvmo_pi.pdf) or visit https://www.rxabbvie.com/pdf/juvmo_pi.pdf.

Reference: 1. JUVMO [package insert]. North Chicago, IL: AbbVie Inc.

7. ADDITIONAL PRESCRIPTION FORM

JPD-072726-A04

PATIENT INFORMATION

First Name*		Last Name*		Date of Birth*	
Sex:*		Primary Phone **		Mobile Phone # (if different)	
☐ Male		☐ Female		Email	
Address*		City*		State*	
Zip*					

Patient Privacy Notice: For information on how we collect and process patient personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit <https://abbv.ie/PrivacyPatient>

PRESCRIBER INFORMATION

Prescriber First Name*		Prescriber Last Name*		Prescriber License #	
Prescriber Address*		City*		State*	
Office Phone #*		Office Fax #*		Office Contact Name	
				Office Contact Email	

Prescriber Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit <https://abbv.ie/PrivacyHCP>

Prescriber certification: I certify that the below therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed JUVMO to the previously identified patient and that I provided the patient with a description of the JUVMO Complete patient support program. I authorize JUVMO Complete to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan (if applicable). I further request that JUVMO Complete proceed with benefit verification, pharmacy triage, and service communications as part of JUVMO Complete. I understand in the absence of a separately signed patient/caregiver HIPAA authorization, no Protected Health Information (PHI) will be returned to me from a specialty pharmacy. **For states that do not allow dual prescriptions or that have specific prescription requirements, please include a separate prescription when faxing the enrollment form.**

7A. PRESCRIPTION FOR PATIENT ON LONG-TERM MODERATE CYP3A INDUCERS

Please refer to the prescribing information for CYP3A inhibitors and strong inducers.

Starting Therapy

☐ JUVMO Titration Pack

Dosing Schedule:

Day 1-4: 0.25 mg Day 9-12: 0.75 mg Day 17-20: 1.5 mg Day 25-40: 3 mg
 Day 5-8: 0.5 mg Day 13-16: 1 mg Day 21-24: 2.25 mg

Directions:*

☐ Take tablet(s) orally twice a day. Use one Titration Pack for the morning dose and the second Titration Pack for the evening dose.

☐

Qty:* 2 packs (40-day supply) Refills:* 0

Moderate CYP3A inducer:*

- ☐ Brand Medically Necessary/Dispense As Written/DAW/Do Not Substitute/May Not Substitute/No Substitution
☐ May Substitute/Product Selection Permitted/Substitution Permissible/Substitution Permitted

Prescriber Signature*

Date:* ____/____/____

Maintenance Therapy

Prescriber note: If needed, based on clinical response and tolerability, the maintenance dosage may be increased to 5 mg three times a day. If further escalation is needed, the dose may be increased by 5 mg every 15 days to the maximum dosage of 45mg daily.

Select only one strength per prescription.

☐ JUVMO 5 mg tablets ☐ JUVMO 10 mg tablets ☐ JUVMO 15 mg tablets

Directions:*

☐ Take 1 tablet orally twice a day ☐ Take 1 tablet orally three times a day

☐

Qty:* Refills:*

- ☐ Brand Medically Necessary/Dispense As Written/DAW/Do Not Substitute/May Not Substitute/No Substitution
☐ May Substitute/Product Selection Permitted/Substitution Permissible/Substitution Permitted

Prescriber Signature*

Date:* ____/____/____

7B. PRESCRIPTION FOR MAINTENANCE DOSE ADJUSTMENTS

Prescriber note: Dose may be titrated upward in 5 mg increments, approximately every 15 days, up to a maximum dose of 15 mg/day.

Select only one strength per prescription.

☐ JUVMO 5 mg tablets ☐ JUVMO 10 mg tablets ☐ JUVMO 15 mg tablets

Directions:* ☐ Take 1 tablet orally once a day ☐

Qty:* Refills:*

- ☐ Brand Medically Necessary/Dispense As Written/DAW/Do Not Substitute/May Not Substitute/No Substitution
☐ May Substitute/Product Selection Permitted/Substitution Permissible/Substitution Permitted

Prescriber Signature*

Date*

INDICATION¹

JUVMO is indicated for the treatment of Parkinson's disease in adults.

SAFETY CONSIDERATIONS¹

JUVMO may cause **hypotension/orthostatic hypotension**; compulsive behavior or **problems with impulse control**; **hallucinations and psychotic-like behavior**; or **dyskinesia**. The most common adverse reactions (≥5%) for JUVMO without levodopa were nausea, headache, dizziness, fatigue, dysgeusia, vomiting, dry mouth, and anxiety. The most common adverse reactions (≥5%) for JUVMO with levodopa were nausea, dyskinesia, dizziness, headache, hallucinations, and orthostatic hypotension.

Please see additional Important Safety Information on page 4.

Please see full Prescribing Information by visiting https://www.rxabbvie.com/pdf/juvmo_pi.pdf.