VALTOCO® (diazepam nasal spray) CIV

PRESCRIPTION FORM FOR PATIENTS ON VALTOCO® (diazepam nasal spray)

Contact Maxor Specialty Pharmacy - Amarillo, Texas
Fax: 1-866-217-8034 · Phone: 1-866-629-6779

PLEASE FILL OUT THE PATIENT INFORMATION AND PATIENT INSURANCE INFORMATION SECTIONS

Patient Information

Patient Name: _____ DOB: ___/___/___ Sex: ☐ M ☐ F ☐ Unspecified

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

Mobile phone: ( ) _____ Home phone: ( ) _____ Email: _____

Your **VALTOCO** prescription will be filled by Maxor Specialty Pharmacy. You will receive a call from Maxor Specialty Pharmacy to confirm delivery of your prescription.

Patient Insurance Information

Prescription Plan Name: _____ Group # _____

Policy # _____ Rx BIN # _____ Rx PCN # _____

Insurance phone: ( ) _____ Policy # _____ Policyholder Name: _____ DOB: ___/___/___

THE FOLLOWING SECTION IS TO BE FILLED OUT BY YOUR DOCTOR'S OFFICE

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI # _____ DEA # _____

Facility Name/Address: _____ City: _____ State: _____ ZIP: _____

Office Contact Name: _____ Email: _____ Phone: ( ) _____ Fax: ( ) _____

Clinical Information for Insurance Prior Authorizations— Please include a copy of patient's clinical notes, if available.

Diagnosis

Diagnosis code(s): _____

_____

Most Recent Antiepileptic Drug Treatment

Approximate Start and End Dates of Most Recent Treatment: _____

Surgical History: _____

Drug Allergies: _____

Prescription (Circle one option for each section)

VALTOCO Dosage Strength: 5 mg 10 mg 15 mg 20 mg

Instructions: _____

BOXES: 1 2 3 4 5 Other# _____ Boxes

REFILLS: 1 2 3 4 5 Other# _____ Refills

Prescriber Authorization (Required)

I authorize the designated pharmacy to act as an agent to initiate and execute the insurance prior authorization process, if necessary, for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice.

Prescriber's Signature: _____ Date ___/___/___

Please complete and sign this form. Fax completed form to 1-866-217-8034.

Please see Important Safety Information, including Boxed Warning, on reverse side.

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Indication

VALTOCO® (diazepam nasal spray) is indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (ie, seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 6 years of age and older.

IMPORTANT SAFETY INFORMATION

WARNING: RISKS FROM CONCOMITANT USE WITH OPIOIDS; ABUSE, MISUSE, AND ADDICTION; and DEPENDENCE AND WITHDRAWAL REACTIONS

- **Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death.**
- **The use of benzodiazepines, including VALTOCO, exposes users to risks of abuse, misuse, and addiction, which can lead to overdose or death.**
- **The continued use of benzodiazepines may lead to clinically significant physical dependence. Although VALTOCO is indicated only for intermittent use, if used more frequently than recommended, abrupt discontinuation or rapid dosage reduction of VALTOCO may precipitate acute withdrawal reactions, which can be life-threatening.**

Adverse Reactions

The most common adverse reactions (at least 4%) were somnolence, headache, and nasal discomfort.

Diazepam, the active ingredient in VALTOCO, is a Schedule IV controlled substance.

To report SUSPECTED ADVERSE REACTIONS, contact Neurelis, Inc. at 1-866-696-3873 or FDA at 1-800-FDA-1088 (www.fda.gov/medwatch).

Please see full Prescribing Information, including Boxed Warning.

NEURELIS™