NUPLAZID®
(pimavanserin) 34mg capsules

Treatment & Service Request Form

acadia connect®
Patient & Caregiver Support
Phone: 1-844-737-2223
Fax: 1-844-737-2224
Long-term care: 1-877-889-0739
*Indicates required field.

Please complete and fax to **1-844-737-2224**, email to **nuplazid@acadiaconnect.com**, or complete the online form at acadiaconnect.com. Please note that email communications sent to Acadia or its third-party service providers may not be encrypted or secured, and safeguards established under the HIPAA Security Rule would not apply to these communications. See Indication and Important Safety Information, including **Boxed WARNING**, on page 2. Please read accompanying full Prescribing Information, also available at NUPLAZIDhcp.com.

1 PATIENT/RESIDENT INFORMATION & INSURANCE

Please fax copies of the front and back of prescription insurance cards.

*Patient first name				**Section required if patient has insurance** ☐ **Patient does not have insurance**	
*Patient last name				*Prescription drug plan	
*Address		*City		*ID number	Phone number
*State	*ZIP	*DOB (MM/DD/YYYY)	Gender	Plan number	Group number
*Patient phone number		*Preferred contact: ☐ Patient ☐ Caregiver		PCN	BIN number
*Caregiver name				Medicare Beneficiary ID	
*Caregiver phone number				Preferred language, if not English	
Patient email/Caregiver email				Preferred pharmacy name	

*Patient resides: ☐ At home ☐ Assisted living ☐ Skilled nursing facility/nursing home

LONG TERM CARE FACILITIES If "Assisted living" or "Skilled nursing facility/nursing home" is selected, please complete the information below. Skip Section 3 if not needed for resident.

*Facility name		*Facility phone number	
Address	City	State	ZIP
Facility contact name		Job title	
Pharmacy name	Pharmacy phone number	NUPLAZID® (pimavanserin) Order on File: ☐ Yes ☐ No	

☐ Check this box if your resident is currently covered under Medicare Part A; expected discharge date:

2 DIAGNOSIS/PRESCRIBER INFORMATION

***Confirmation of diagnosis required** ☐ Hallucinations and delusions associated with Parkinson's disease psychosis (PDP). ☐ Other diagnosis:_____	***Please confirm dose:** ☐ 34 mg capsule ☐ Other:_____

*Prescriber first and last name	*Prescriber NPI number	State license number (If available)	
Practice/Facility name	*Address		
Primary contact name	*City	*State	*ZIP
Prescriber email	*Phone number	*Fax	

Prescriber Authorization: I attest that I have obtained written permission, in the event it is required under applicable federal and/or state law, of my patient (or the patient's legal representative) for the release of my patient's Protected Health Information ("PHI") to Acadia Pharmaceuticals Inc. or its representatives or agents (collectively "Acadia") as may be necessary for the patient's participation in a program designed to assist patients in determining their insurance coverage for NUPLAZID that I have elected to prescribe. I direct Acadia to convey, on my behalf, any prescription information delivered to Acadia for NUPLAZID by any means under applicable law to the dispensing pharmacy chosen by or for the patient, to the patient's health insurance company, or to other third parties as may be necessary to assist this patient with filling his/her prescription for NUPLAZID, with securing any insurance coverage for NUPLAZID to which the patient is entitled, or other third parties to assist with patient assistance or reduced-cost medication. I understand I am to comply with the state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. I agree that Acadia may contact me for additional information relating to NUPLAZID, including but not limited to via email, fax, and telephone. I authorize Acadia to transmit the above prescription to the pharmacy.

》_____ _____

*Prescriber or authorized agent signature (No stamp allowed) *Date

3 PRESCRIPTION INFORMATION

Skip this section if NUPLAZID® (pimavanserin) order is on file for long term care resident.

Known drug allergies: ☐ None | Concurrent medications (attach list, if more space is needed): ☐ None

NUPLAZID® (pimavanserin) ONGOING PRESCRIPTION If marking checkbox for ongoing prescription already sent to pharmacy or prefer to e-prescribe, skip prescription fields.

☐ Already provided prescription to _____ (pharmacy name) | ☐ Will e-prescribe once Acadia Connect confirms appropriate pharmacy

☐ Refills (# of refills): _____ | ☐ sig. Take 34 mg capsule orally, once daily ☐ Dispense: 30-day supply ☐ Other† _____ # of days to be dispensed: _____

Dispense as written 》_____ *Prescriber signature Date

Substitution permitted 》_____ Prescriber signature Date

FREE 14-DAY SUPPLY OF NUPLAZID® (pimavanserin) Note: Limited to a 14-day supply per fill **(only for patients diagnosed with hallucinations and delusions associated with PDP)**

☐ E-prescription already sent to RareMed Pharmacy | 14-day supply with 1 refill ☐ sig. Take 34 mg capsule orally, once daily ☐ Other† _____

Acadia Connect® may send a second Free 14-Day Supply if extra time is needed. 》_____ _____

*Prescriber signature Date

†See Important Safety Information for dosing recommendations (including drug/drug interactions).

Note: Free 14-day Supply of NUPLAZID to be dispensed by RareMed Pharmacy. NUPLAZID will only be dispensed and delivered to facilities that accept free product.

HIPAA AUTHORIZATION Please read and sign below if you agree.

I hereby authorize and direct my health care providers (including physicians providers of long-term care, and pharmacies) and health insurance companies and each of their respective representatives, employees, staff, and agents (collectively "Providers") to disclose my Protected Health Information ("PHI") to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") for obtaining Acadia Connect support services. I understand that this PHI may include, but is not limited to, my name, address, phone number, and other contact information; information relating to my medical condition, treatment, care management, and health insurance; as well as information provided on this form and any prescription. I understand that pharmacies may receive remuneration (payment) from Acadia for providing patient support services and disclosing associated PHI to Acadia pursuant to this Form.

I authorize Acadia to use and further disclose the PHI it receives as a result of this Form for:

- Providing reimbursement support associated with the filling of my prescription, including verification of my insurance benefits and assistance in securing coverage to which I am entitled.
- Facilitating the provision of patient assistance, reduced-cost medication, co-pay assistance, and/or other product-related services offered by Acadia, patient advocacy organizations, or other third parties.
- Sending me communications related to the Acadia Connect support services.
- Administrative purposes related to the above services.
- Following de-identification, use for research purposes.

I authorize Acadia to contact me using the contact information I have provided this Form for the above purposes. I also authorize Acadia to report back to my Providers any PHI about me that Acadia may create or receive.

I understand that once my PHI is disclosed to Acadia pursuant to this Form, it may be no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and may be subject to re-disclosure.

I understand that I may refuse to sign this Form and my refusal will not affect the treatment I receive from my Providers, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. I also understand that I may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to the address below; however, this cancellation will not apply to any PHI already used or disclosed in reliance on this Form before notice of the cancellation is received by my Providers.

I understand that this authorization is valid for a period of 10 years or for a shorter period dictated by applicable state law. I understand that I will be provided with a signed copy of this authorization by the Provider who collects it from me.

Further information concerning Acadia's privacy practices can be found at https://www.acadia-pharm.com/privacy. If you are a resident of California, a description of the personal information collected by Acadia and your rights under the California Consumer Privacy Act can be found at this address.

Address to Opt Out of Communications or to Cancel This Form:

Acadia Connect, PO Box 15713, Pittsburgh, PA 15244

» Patient signature _____ Date _____

» Personal representative (if applicable) signature _____ Date _____

AUTHORIZATION TO DISCLOSE INFORMATION TO INDIVIDUALS INVOLVED IN MY CARE (optional)

I further authorize Acadia Pharmaceuticals Inc. to discuss the coordination of my care with the following family member(s) and/or caregiver(s):

Authorized representative Name (please print) _____ Relationship to patient _____

» Patient signature/legal guardian signature _____ Date _____

Indication
NUPLAZID is indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.

Important Safety Information

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

- **Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.**
- **NUPLAZID is not approved for the treatment of patients with dementia who experience psychosis unless their hallucinations and delusions are related to Parkinson's disease.**

- **Contraindication:** NUPLAZID is contraindicated in patients with a history of a hypersensitivity reaction to pimavanserin or any of its components. Rash, urticaria, and reactions consistent with angioedema (e.g., tongue swelling, circumoral edema, throat tightness, and dyspnea) have been reported.
- **Warnings and Precautions:** QT Interval Prolongation
  - NUPLAZID prolongs the QT interval. The use of NUPLAZID should be avoided in patients with known QT prolongation or in combination with other drugs known to prolong QT interval (e.g., Class 1A antiarrhythmics, Class 3 antiarrhythmics, certain antipsychotics or antibiotics).
  - NUPLAZID should also be avoided in patients with a history of cardiac arrhythmias, as well as other circumstances that may increase the risk of the occurrence of torsade de pointes and/or sudden death, including symptomatic bradycardia, hypokalemia or hypomagnesemia, and presence of congenital prolongation of the QT interval.
- **Adverse Reactions:** The adverse reactions (≥2% for NUPLAZID and greater than placebo) were peripheral edema (7% vs 2%), nausea (7% vs 4%), confusional state (6% vs 3%), hallucination (5% vs 3%), constipation (4% vs 3%), and gait disturbance (2% vs <1%).
- **Drug Interactions:**
  - Coadministration with strong CYP3A4 inhibitors increases NUPLAZID exposure. Reduce NUPLAZID dose to 10 mg taken orally as one tablet once daily.
  - Coadministration with strong or moderate CYP3A4 inducers reduces NUPLAZID exposure. Avoid concomitant use of strong or moderate CYP3A4 inducers with NUPLAZID.

Dosage and Administration
Recommended dose: 34 mg capsule taken orally once daily, without titration, with or without food.

NUPLAZID is available as 34 mg capsules and 10 mg tablets.

Please read the accompanying full Prescribing Information, including **Boxed WARNING**, also available at NUPLAZIDhcp.com.

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