ONCE-DAILY
NUPLAZID®
(pimavanserin) 34mg capsules

Service Request Form
Long-Term Care

NUPLAZID connect™
YOUR LINK TO TREATMENT & BENEFITS SUPPORT

Phone: 1-844-737-2223 · Fax: 1-844-737-2224
Long-term care phone: 1-877-889-0739

Completion of this form does not initiate treatment but is intended to request access and reimbursement services.
See Important Safety Information including **Boxed WARNING** on page 2. Please read accompanying full Prescribing Information.

Please complete and fax this page to **1-844-737-2224**. Alternatively, you may also email the Service Request Form to **NUPLAZIDconnect@lashgroup.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.

1 SERVICES NEEDED
To be completed by prescribing physician, nurse, or facility pharmacist.

*Indicates required field.

*Please select the NUPLAZIDconnect™ services needed (check all that apply):

☐ Perform a benefits investigation ☐ Prior authorization or appeals support ☐ Provide your resident with financial assistance options

2 RESIDENT INFORMATION/INSURANCE
A copy of the resident's prescription drug plan insurance card can be provided instead of completing the insurance section below.

*Resident name

*Facility name | *DOB (MM/DD/YYYY) | Gender

*Resident/Caregiver email | Resident phone number

Caregiver name | Caregiver phone number

*Preferred contact: ☐ Resident ☐ Caregiver | Preferred language (if not English)

Section required if resident has insurance ☐ Resident does not have insurance

*Prescription drug plan | *Phone number

*ID number | Plan number

Cardholder name | Group number

Relationship to cardholder | PCN/BIN number

*Resides at:

☐ Skilled nursing facility/nursing home
☐ Assisted living

*Primary facility contact | *Job title | *Address

*Facility name | *Facility phone number | *City | *State | *ZIP code

Pharmacy name | Pharmacy phone number

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

3 DIAGNOSIS INFORMATION/PRESCRIBER AUTHORIZATION
To be completed by prescribing physician, nurse, or facility pharmacist.

*Please confirm diagnosis: ☐ Hallucinations and delusions associated with Parkinson's disease (PD) psychosis or ☐ Other diagnosis: _____

Prescriber Authorization: I attest that I have obtained the HIPAA authorization, and any other written permission that may be required under applicable law, of my patient (or the patient's legal representative) for the release of my patient's Protected Health Information ("PHI") to Lash or its representatives or agents (the "Program") as may be necessary for the patient's participation in a program designed to assist patients in determining their insurance coverage for NUPLAZID® (pimavanserin) that I have elected to prescribe. I have explained to my patient, and the patient's authorization explains in writing, that the PHI will be used in connection with the Program and that the Program can use, and further disclose, any of the PHI that they receive from me as necessary to provide reimbursement support and other services to me and to my patient in connection with NUPLAZID. I direct the Program to convey, on my behalf, any prescription information delivered to the Program for NUPLAZID to the patient's health insurance company, to the manufacturer of NUPLAZID, 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 to the manufacturer 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. Non-compliance of state-specific requirements could result in outreach to me or my office. I understand that the Program will use and disclose this information only: (1) in connection with the Program, including but not limited to performing a preliminary verification of my patient's insurance coverage for NUPLAZID and assessing my patient's eligibility for participation in the Program, and (2) as otherwise required or permitted by law, and the HIPAA authorization and written permissions are consistent with this approach. I agree that the Program may contact me for additional information relating to the Program or NUPLAZID, including but not limited to via email, fax, and telephone.

*Prescriber or authorized agent name | *Prescriber NPI number | Prescriber phone number

>> *Prescriber or authorized agent (i.e., nurse) signature (no stamp allowed): _____ *Date: _____

If you do not have a HIPAA authorization on file for this resident, please have them review and sign the HIPAA authorization section on page 2 of this Service Request Form.

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HIPAA AUTHORIZATION Please read these consent statements before signing front of form.

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my Protected Health Information ("PHI"), including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to ACADIA Pharmaceuticals Inc. ("ACADIA") and its representatives or agents, including ACADIA's NUPLAZIDconnect™ Support Center operated by The Lash Group, Inc., on behalf of ACADIA (collectively, "the Program") to be used for the following:

- **Reimbursement support associated with the filling of my prescription for NUPLAZID® (pimavanserin), including the performance of a preliminary insurance verification and the securing of any insurance coverage for NUPLAZID to which I am entitled**
- **Facilitating the provision of patient assistance, reduced-cost medication, and/or other NUPLAZID-related services offered by the Program**

I understand that my pharmacy provider(s) will disclose to the Program or its representatives and agents certain PHI regarding the dispensing of my NUPLAZID prescription and that such disclosure will result in remuneration to my pharmacy provider(s). I understand that once my PHI is disclosed under this authorization, it is no longer protected by federal privacy laws and may be further disclosed by the Program; however, the Program agrees to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law. I understand that I may refuse to sign this authorization and that treatment, payment, or eligibility for benefits is not conditioned on my signing this authorization. I understand that I am entitled to a copy of this authorization. I understand that this authorization is for a period of 10 years or for a shorter period dictated by applicable state law. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to: NUPLAZIDconnect, PO Box 220305, Charlotte, NC 28222-0305, but that this cancellation will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my health plans or healthcare providers. I authorize ACADIA and its healthcare partners to forward the prescription provided by my physician, by fax or by another mode of delivery, to the pharmacy.

>> Resident/Legal guardian signature: _____ Date: _____

AUTHORIZED REPRESENTATIVE CONSENT (optional)

I further authorize the Program to discuss my treatment with the following authorized representative(s):

Authorized representative (1) name (please print): _____ Relationship to patient: _____

Authorized representative (2) name (please print): _____ Relationship to patient: _____

>> Resident/Legal guardian signature: _____ Date: _____

Indication

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

Important Safety Information for NUPLAZID (pimavanserin)

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-related psychosis unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.

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.

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 including Class 1A antiarrhythmics or Class 3 antiarrhythmics, certain antipsychotic medications, and certain 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 most common 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 (e.g., ketoconazole) increases NUPLAZID exposure. Reduce NUPLAZID dose to 10 mg taken orally as one tablet once daily. Coadministration with strong CYP3A4 inducers may reduce NUPLAZID exposure. Monitor patients for reduced efficacy and an increase in NUPLAZID dosage may be needed.

Pediatric Use: Safety and efficacy have not been established in pediatric patients.

Dosage and Administration

Recommended dose: 34 mg taken orally once daily, without titration.

Please read the accompanying full Prescribing Information.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.
You can also call ACADIA Pharmaceuticals Inc. at 1-844-4ACADIA (1-844-422-2342).

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