**Long-Term Care**

**Completion of this form does not initiate treatment but is intended to request access and reimbursement services.**

# NUPLAZID® Service Request Form

(pimavanserin) tablets

NUPLAZID connect™
YOUR LINK TO TREATMENT & BENEFITS SUPPORT

Please see Important Safety Information, including **Boxed Warning**, on page 2.

Please fax this completed form to **1-844-737-2224**.

Phone: 1-877-889-0739 • Fax: 1-844-737-2224

*Indicates required field.

## STEP 1: 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 first name _____ *Resident last name _____

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

Resident email _____ Resident phone number _____

Caregiver name _____ Caregiver phone number _____

Caregiver email _____ *Preferred contact: ☐ Resident ☐ Caregiver

Preferred language (If not English) _____ Preferred contact time: ☐ Morning ☐ Afternoon ☐ Evening

**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:

☐ Assisted Living

☐ Skilled Nursing Facility/Nursing Home

*Primary facility contact _____ *Job title _____ *Address _____

*Facility name _____ *Phone number _____ *City _____ *State _____ *ZIP code _____

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

## STEP 2: SERVICES NEEDED

To be completed by prescribing physician, nurse, or facility pharmacist

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

☐ Perform a benefits investigation on behalf of your resident

☐ Support you in the prior authorization/appeals process, if required by your resident's insurance company

☐ Provide recommendations on financial assistance programs, if your resident is eligible

## STEP 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 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 or authorized agent (ie, 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.**

## HIPAA AUTHORIZATION

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, 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 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. 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.

>> Resident signature/legal guardian signature _____ Date _____

## AUTHORIZED REPRESENTATIVE CONSENT (optional)

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

Authorized representative (1) Name (please print) _____ Relationship to resident _____

Authorized representative (2) Name (please print) _____ Relationship to resident _____

>> Resident signature/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) 17-mg Tablets

**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 hypersensitivity reaction to pimavanserin or any of its components. Reactions have included rash, urticaria, tongue swelling, circumoral edema, and throat tightness.

**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:** Strong CYP3A4 inhibitors (eg, ketoconazole) increase NUPLAZID concentrations. Reduce the NUPLAZID dose by one-half. Strong CYP3A4 inducers may reduce NUPLAZID exposure, monitor for reduced efficacy. Increase in NUPLAZID dosage may be needed.

**Renal Impairment:** No dosage adjustment for NUPLAZID is needed in patients with mild to moderate renal impairment. Use of NUPLAZID is not recommended in patients with severe renal impairment.

**Hepatic Impairment:** Use of NUPLAZID is not recommended in patients with hepatic impairment. NUPLAZID has not been evaluated in this patient population.

**Pregnancy:** Use of NUPLAZID in pregnant women has not been evaluated and should therefore be used in pregnancy only if the potential benefit justifies the potential risk to the mother and fetus.

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

### Dosage and Administration

Recommended dose: 34 mg per day, taken orally as two 17-mg tablets once daily, without titration.

**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).**

**Please read the accompanying full Prescribing Information or visit NUPLAZIDhcp.com.**



ACADIA® Pharmaceuticals