ONCE-DAILY
NUPLAZID®
(pimavanserin) 34mg capsules

Treatment Form

NUPLAZID connect

Phone: 1-844-737-2223 • Fax: 1-844-737-2224
Long-term care phone: 1-877-889-0739
*Indicates required field.

See Indication and Important Safety Information including **Boxed WARNING** on page 2.
Please complete and fax the Treatment Form to **1-844-737-2224** or email 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 PATIENT INFORMATION/INSURANCE

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

I have read and agree to HIPAA authorization on page 2 >> Patient signature Date

>> Signature of personal representative (if applicable) Date Description of authority

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

*Patient resides: ☐ At home ☐ Assisted Living ☐ Skilled Nursing Facility/Nursing Home

Preferred specialty pharmacy: ☐ Accredo ☐ Advanced Care Scripts ☐ AllianceRx Walgreens Prime ☐ CVS Specialty ☐ Humana ☐ Other _____

If "Assisted Living" or "Skilled Nursing Facility/Nursing Home" is selected, please complete the information below:

*Facility name		*Facility phone number	
Address	City	State	ZIP code
Facility contact name		Job title	
Pharmacy name		Pharmacy phone number	

2 PRESCRIBER INFORMATION

*Prescriber name	*Prescriber NPI number	State license number		
Practice/Facility name	*Address	*City	*State	*ZIP code
Primary contact name	*Phone number	*Fax		

Prescriber Authorization: I attest that I have obtained written permission that may be 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, the prescription and any prescription information delivered to ACADIA for NUPLAZID 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 signature (No stamp allowed) _____ Date _____

3 DIAGNOSIS/PRESCRIPTION INFORMATION

*Please confirm diagnosis ☐ Hallucinations and delusions associated with Parkinson's disease (PD) psychosis (includes G20 Parkinson's disease) ☐ Other diagnosis _____

Coding must be to the highest level of specificity and all coding decisions are ultimately the responsibility of each prescribing health care professional.

*NUPLAZID® (pimavanserin) ONGOING PRESCRIPTION

NUPLAZID® (pimavanserin) ☐ Refills (# of refills):

☐ sig. Take 34 mg capsule orally, once daily ☐ Dispense: 30-day supply

☐ Other* # of days to be dispensed:

Substitution permitted >> Prescriber signature Date

Dispense as written >> Prescriber signature Date

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

FREE 14-DAY SUPPLY OF NUPLAZID

Note: Limited to a 14-day supply per fill

(only for patients diagnosed with hallucinations and delusions associated with PD psychosis)

NUPLAZID® (pimavanserin) Refills (# of refills): 1

☐ sig. Take 34 mg capsule orally, once daily ☐ Dispense: 14-day supply

☐ Other # of days to be dispensed:

NUPLAZIDconnect™ may send a second Free 14-Day Supply if extra time is needed.

>> _____ _____
Prescriber signature Date

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

By signing this authorization, I authorize my health plans, physicians, long-term care and other health care providers, and pharmacies (collectively "Providers") to disclose my Protected Health Information ("PHI"), including, but not limited to, my name, address and phone number, 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. and its representatives or agents (collectively "ACADIA"). I authorize and direct my Providers to make disclosures of PHI to ACADIA for the following purposes:

- Reimbursement support associated with the filling of my prescription for NUPLAZID, including the performance of an insurance verification and assisting in 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 ACADIA
- Receiving marketing and promotional communications related to my disease condition, NUPLAZID, and other information from ACADIA. I hereby give consent to ACADIA, its affiliates and their agents and representatives, and my Providers to send communications and information to me via the contact information provided.

With respect to any disclosures by my pharmacies, I understand that my pharmacies will receive remuneration (payment) from ACADIA for making disclosures of PHI and/or support services to ACADIA; however, ACADIA 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 once my PHI is disclosed under this authorization, it is no longer protected by Federal privacy laws, including HIPAA, and may be further disclosed by ACADIA.

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 will be provided with a signed copy of this Authorization, by the Provider who collects it from me.

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 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 Providers.

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 (1) Name (please print) _____ Relationship to patient _____

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

>> Patient signature/legal guardian signature _____ Date _____

Important Safety Information and Indication 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 or moderate CYP3A4 inducers reduces NUPLAZID exposure. Avoid concomitant use of strong or moderate CYP3A4 inducers with NUPLAZID.

Indication

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

Dosage and Administration

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

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

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

ACADIA® Pharmaceuticals

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