ONCE-DAILY
NUPLAZID®
(pimavanserin) 34mg capsules

Treatment Form

See Important Safety Information including **Boxed WARNING** on page 2.
Please fax this completed form to **1-844-737-2224**.

NUPLAZID connect

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

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

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 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 dispensing pharmacy chosen by or for the patient, 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. 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 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 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.

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 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.

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 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.

Indication

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

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 (NDC: 63090-340-30), 17 mg tablets (NDC: 63090-170-60), and 10 mg tablets (NDC: 63090-100-30).

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

ACADIA® Pharmaceuticals