PRESCRIPTION AND ENROLLMENT FORM

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

NUPLAZID® (pimavanserin) 34mg capsules | acadia connect®

Healthcare providers:

- Please submit completed enrollment form, copy of all insurance cards (front and back):
  - Fax to 1-844-737-2224
  - Email to nuplazid@acadiaconnect.com
  - Or complete the online form at acadiaconnect.com
- **Long-term care:** call 1-877-889-0738 or fax Prescription Enrollment Form to: 1-844-737-2224
- If your office has not received a confirmation fax that your enrollment form has been received within one (1) business day after submission, please resubmit or call Acadia Connect® at 1-844-737-2223, Monday to Friday, 8 AM to 8 PM ET
- 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 3. Please read accompanying full Prescribing Information, also available at NUPLAZIDhcp.com.

***Indicates required field.**

1 PATIENT/RESIDENT INFORMATION

***First name:** _____ Middle initial: _____ ***Last name:** _____ ***Gender:** _____

***Address:** _____ ***City:** _____ ***State:** _____ ***ZIP code:** _____ ***Date of birth (MM/DD/YYYY):** _____

***Patient phone number:** _____ ***Preferred contact:** _____

***Care partner name:** _____ ***Care partner phone number:** _____

***Patient email/care partner email:** _____

Long-term care: ☐ Assisted living ☐ Skilled nursing facility/nursing home ☐ Does not apply

If "Assisted living," or "Skilled nursing facility/nursing home" is selected, complete this information. If "Does not apply" is selected, skip to Section 2.

Facility name: _____ Facility phone number: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Facility contact name: _____ Job title: _____

Pharmacy name: _____ Pharmacy phone number: _____

Facility contact for prior authorizations: _____ 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 INSURANCE INFORMATION Please fax copies of the front and back of prescription insurance cards.

Section required if patient has insurance. ☐ Patient does not have insurance

Prescription drug plan: _____ ID number: _____ Phone number: _____

Group number: _____ PCN number: _____ Plan number: _____

Medicare beneficiary ID: _____ BIN number: _____

Preferred language, if not English: _____ Preferred pharmacy name: _____

3 PRESCRIBER INFORMATION Skip this section if NUPLAZID order is on file for long-term care resident.

***Prescriber first and last name (please print):** _____ ***Prescriber NPI number:** _____

Practice/Facility name: _____ ***Address:** _____

Primary contact name: _____ ***City:** _____ ***State:** _____ ***ZIP code:** _____

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 (eg, nurse) signature** (No stamp allowed): _____ ***Date:** _____

4 CLINICAL INFORMATION

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

***Confirmation of diagnosis required**

☐ Hallucinations and delusions associated with Parkinson's disease psychosis (PDP)

☐ Other diagnosis: _____

***Please confirm dose:**

☐ 34 mg capsule

Other: _____

5 PRESCRIPTION INFORMATION Skip this section if NUPLAZID order is on file for long-term care resident.

To help your patient start therapy as quickly as possible, please complete both sections below.

NUPLAZID® (pimavanserin) ONGOING PRESCRIPTION

☐ Take 34 mg capsule by mouth orally once daily for 30 days with _____ refills

☐ Other: _____

☐ Will e-prescribe once Acadia Connect® confirms appropriate pharmacy

☐ Already provided prescription to _____ (pharmacy name)

NUPLAZID Free 30-Day Quick Start†

Note: Limited to a 30-day supply per fill (only for patients diagnosed with hallucinations and delusions associated with PDP). Program Terms and Conditions apply: https://www.acadiaconnect.com/nuplazid/patient-caregivers

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

☐ E-prescription already sent to RareMed Pharmacy

☐ Other: _____

Dispense as written ***Prescriber signature** _____ ***Date:** _____

Substitution permitted ***Prescriber signature** _____ ***Date:** _____

†Available for eligible patients starting therapy. This offer is limited to one per patient and is not transferable. The free trial is not health insurance. Acadia Connect® patient eligibility and terms and conditions apply.

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PRESCRIPTION AND ENROLLMENT FORM

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NUPLAZID® (pimavanserin) 34mg capsules | acadia connect®

Patient's Name: _____ Date of Birth (MM/DD/YYYY): _____

6 PATIENT AUTHORIZATION & ACADIA CONNECT® PROGRAM CONSENT

DESCRIPTION OF THE PROGRAM:
The Acadia Connect® & Acadia Connect® Commercial Copay Card Program, or the "Program" or "Services," helps you and (if you are a guardian or authorized representative) your ward ("patient") learn about, obtain, and access NUPLAZID, including through copay and related financial assistance for NUPLAZID. Program Terms and Conditions apply: https://www.acadiaconnect.com/nuplazid/patient-caregivers.

Required **SERVICES CONSENT (Required to participate in the Program) (see below for details)**
☐ **I consent to the Services as described below.**

NUPLAZID AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION SIGNATURE. (Required to participate in the Program) (see below for details)

Sign Here ***Patient/Authorized Representative:** _____ ***Date:** _____

***Full name (please print):** _____ Relationship to patient: _____

Additional care partners (optional) (see below for details)

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

CONSENT TO RECEIVE TEXTS (Optional)
☐ **I consent** ☐ **I do not consent**

I agree that Acadia may contact me via text message at the phone number on page 1 regarding the Program and other Acadia products and services. I confirm that I am the subscriber for the mobile telephone number(s) I provided on this form, and I agree to notify Acadia promptly by calling 1-844-737-2223 or by mailing Acadia Connect®, PO Box 15713, Pittsburgh, PA 15244 if any of my numbers change in the future. I understand that my wireless service provider's message and data rates may apply. I can opt out of future communications by responding STOP to any text. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM AND THAT I DO NOT NEED TO AGREE TO RECEIVE CALLS OR TEXTS AS A CONDITION OF PURCHASING OR RECEIVING ANY GOODS OR SERVICES FROM ACADIA.

ACADIA NEWS AND UPDATES (Optional)
☐ **I want to receive additional information from Acadia based on my health and caregiving interests.**

I agree that Acadia Pharmaceuticals Inc. and its representatives and agents (collectively, "Acadia") may use and disclose personal data about me and (if I am a care partner) my patient to send promotional communications about Acadia products and services. To provide me with this service, Acadia may process health information about me or my patient (as applicable), such as diagnosis, symptoms, medication, and inferences derived from the same, and disclose this data to its service providers and affiliates, and as otherwise described in the NUPLAZID Authorization for Disclosure of Health Information, below, and Acadia's privacy policy.

I may unsubscribe at any time.

SERVICES CONSENT (Required to participate in the Program)

I agree to enroll in the Services, or (if I am a care partner), I agree on behalf of the patient to enroll the patient in the Services. I agree that Acadia and its service providers may collect, use, and disclose health information and personal data about me and (if I am a care partner) the patient as necessary to facilitate participation in the Services and as otherwise described in the NUPLAZID Authorization for Disclosure of Health Information, below, and Acadia's privacy policy, available here: www.acadia.com/privacy. I also agree that Acadia may contact me and the patient, as applicable, at the contact information I have provided on this form, including by calling, texting, or emailing, for purposes related to participation in the Services.

NUPLAZID AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (see continued on next page)

I, on behalf of myself or (if I am a personal representative) my patient, hereby authorize and direct my or my patient's healthcare providers (including physicians, prescribers, providers of long-term care, and pharmacies) health insurance companies, specialty pharmacies, and each of their respective representatives, employees, staff, and agents (collectively "Providers"), and any care partners or other individuals whom I list above ("Additional Care Partners") to use Protected Health Information ("PHI") about me or my patient (as applicable), and disclose it to each other and to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") to facilitate participation in the Services and to receive the Acadia News and Updates if I selected this option above (collectively "Program"). I understand that this PHI may include, without limitation, contact information (name, address, phone number, email) and information about healthcare (medical condition, treatment and medications, care management, and health insurance). I understand that pharmacies may receive remuneration (payment) from Acadia for providing patient support services and disclosing associated PHI to Acadia pursuant to this authorization.

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6 PATIENT AUTHORIZATION & ACADIA CONNECT® PROGRAM CONSENT (continued)

NUPLAZID AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (continued)

I also authorize Acadia to disclose to Providers and Additional Care Partners for Program purposes any information about me or (if I am a personal representative) my patient, that Acadia may create or receive. I understand that information used or disclosed pursuant to this authorization may no longer be protected by certain state or federal privacy laws and may be subject to redisclosure. I understand that I may refuse to sign this authorization, and my refusal will not affect the treatment I receive or my patient (as applicable) receives from Providers, nor will it affect my or my patient's (as applicable) enrollment or eligibility for health insurance benefits to which I am or my patient (as applicable) is otherwise entitled. However, if I refuse to sign this authorization, I or my patient (as applicable) will not be able to participate in the Program, as the information used and disclosed as described in this form is necessary to facilitate participation in the Program. I also understand that I may cancel (revoke) this authorization at any time and request a signed copy of this authorization by calling 1-844-737-2223 or by writing to Acadia Connect®, PO Box 15713, Pittsburgh, PA 15244; however, this cancellation will not apply to any information already used or disclosed in reliance on this authorization before notice of the cancellation is received. I understand that this authorization is valid for a period of 5 years or for a shorter period dictated by applicable state law.

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.**

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

- **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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