Daybue® (trofinetide)

ACADIA CONNECT® PROGRAM CONSENT

acadia connect®

Acadia Connect is a patient and family support program that connects you and your family with educational support and resources before and after DAYBUE® (trofinetide) is prescribed. The team will help you with

- Understanding your loved one's diagnosis
- Providing information about DAYBUE
- Answering questions on insurance coverage
- Information on potential financial assistance options
- Support and education throughout the DAYBUE treatment journey

Consent is required to enroll a patient in Acadia Connect.

The authorized parent/legal guardian should complete, sign, and submit the completed form via fax to 1-888-385-2748 or email to DAYBUE@AcadiaConnect.com.

1 PATIENT/PARENT/LEGAL GUARDIAN INFORMATION

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Date of Birth (MM/DD/YYYY): _____ Gender: _____

PARENT/LEGAL GUARDIAN INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Relationship to Patient: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Home Phone #: _____ Mobile Phone #: _____

Work Phone #: _____ Preferred Phone #: ☐ Home ☐ Work ☐ Mobile

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening Can We Leave a Message? ☐ Yes ☐ No

Email Address: _____

2 PRESCRIBER INFORMATION

Prescriber Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

3 ADDITIONAL HEALTHCARE PROVIDERS (Please complete the table with information to the best of your knowledge.)

CARE TEAM MEMBER ROLES	PROVIDER OFFICE	NAME	OFFICE PHONE/FAX
Pediatrician			
Family/Internal Medicine			
Neurologist			
Gastroenterologist			
Therapeutic Services (eg, physical or speech)			
School Nurse/ Daycare Center			
Other Healthcare Providers			

4 PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(Please read and sign below if you agree.)

I hereby authorize and direct my child's or ward's (collectively, "child's") healthcare providers (including physicians, prescribers, providers of long-term care, and pharmacies) and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to use my child's Protected Health Information ("PHI") and/or disclose it to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") to assist with my child obtaining DAYBUE and Acadia Connect Support Services (we refer to Acadia Connect and the Acadia Copay Card Program collectively as "Acadia Connect Support Services" or the "Program"). I understand that this PHI may include, but is not limited to, name, address, phone number, and other contact information; information relating to my child's medical condition, treatment, care management, and health insurance; as well as information provided on this authorization and any prescription. 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.

I further authorize Acadia to use health information it collects about my child, and to disclose it to third parties, including, but not limited to, specialty pharmacies, health plans, insurance companies, and patient assistance programs in relation to my child's obtaining DAYBUE and/or participating in the Program, including communicating with me and my child about the Program; investigating insurance benefits, eligibility, and coverage; providing financial assistance for copay or out-of-pocket payments; assessing eligibility for free medication supply; coordinating care; and coordinating the delivery of medication. I also authorize Acadia to disclose to my child's Providers for Program purposes any information about me and my child that Acadia may create or receive.

I understand that once my child's PHI or other information about my child is disclosed to or by Acadia pursuant to this authorization, it may no longer be protected by state and federal privacy laws and may be subject to re-disclosure. I understand that I may refuse to sign this authorization, and my refusal will not affect the treatment my child receives from my child's Providers, nor will it affect my child's enrollment or eligibility for health insurance benefits to which my child is otherwise entitled. However, if I refuse to sign this authorization on behalf of my child, my child will not be able to participate in the Program, as the disclosures of my child's PHI and other information about my child by my child's Providers and Acadia for Program purposes are necessary to facilitate my child's participation in the Program. I also understand that I may cancel (revoke) this authorization at any time by calling 844-737-2223 or by mailing Acadia Connect, 1710 Shelby Oaks Dr. Ste 3, Memphis, TN 38134; however, this cancellation will not apply to any PHI or other 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 10 years or for a shorter period dictated by applicable state law. I understand that my child and I have a right to receive and will be provided with a signed copy of this authorization by Acadia. I may request additional copies by contacting Acadia by calling 844-737-2223 or by mailing Acadia Connect, 1710 Shelby Oaks Dr. Ste 3, Memphis, TN 38134.

Sign Here Patient/Parent/Legal Guardian: _____ Date: _____

Name: _____ Relationship to Patient: _____

4 PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (cont)

(Please read and sign below if you agree.)

PROGRAM SIGN-UP & CONSENT TO PROCESS HEALTH INFO FOR PROGRAM PURPOSES (Required to participate in the Program)

I agree, on behalf of my child, for my child to enroll in Acadia Connect and, if my child is eligible, I agree for my child to enroll in the Program. I understand that any assistance with my cost-sharing or co-payment for DAYBUE will be made in accordance with the Program Terms and Conditions at https://www.acadiaconnect.com/public/daybue/caregivers/about.

I also agree that Acadia may collect and process health information about my child, including the details I provided on this form, information about my child's participation in the Program, and other health information about my child, such as my child's diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my child's participation in the Program, including to investigate insurance benefits, eligibility, and overage; provide financial assistance for copay or out-of-pocket payments; eligibility for free medication supply; coordinating care; coordinating the delivery of medication. I also agree that Acadia may contact me at the contact information I have provided on this form, including by calling or emailing me, for purposes related to my child's participation in the Program.

I understand that I am not required to consent to this processing of my child's health information. However, if I do not consent, my child will not be able to participate in the Program, as processing of my child's health information is necessary for Acadia to facilitate our participation in the Program.

If I consent, I have the right to withdraw consent on behalf of my child at any time by calling 844-737-2223 or mailing Acadia Connect, 1710 Shelby Oaks Dr. Ste 3, Memphis, TN 38134. For more information about Acadia's privacy practices, go to https://acadia.com/en-us/legal-policies/privacy. For additional privacy disclosures for California residents, go to https://acadia.com/en-us/legal-policies/privacy#california.

☐ I consent

CONSENT TO RECEIVE TEXTS (Optional)

I agree that Acadia may contact me via text message at the above phone number 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 844-737-2223 or by mailing Acadia Connect, 1710 Shelby Oaks Dr. Ste 3, Memphis, TN 38134 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.

☐ I consent

☐ I do not consent

AUTHORIZATION TO DISCLOSE INFORMATION TO INDIVIDUALS INVOLVED IN MY CARE (Optional)

I further authorize Acadia to discuss the coordination of my child's care with the family member(s) and/or caregiver(s) I list below. These individual(s) have my full permission to obtain and disclose personal and medical information about my child from Acadia.

Authorized Representative(s) (please print):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient/Parent/Legal Guardian (print name): _____

Sign Here Patient/Parent/Legal Guardian: _____ Date: _____

Please submit completed consent form via fax to 1-888-385-2748 or email to DAYBUE@AcadiaConnect.com

ACADIA®