Daybue® (trofinetide)

PRESCRIPTION AND ENROLLMENT FORM

acadia connect®

Healthcare providers:

- Please submit completed enrollment form, copy of all insurance cards (front and back), and copy of patient's clinical chart notes to Acadia Connect®
- Have the parent/legal guardian read pages 3-5 and sign where indicated
- Fax the completed form to Acadia Connect at 1-888-385-2748
- 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, 8AM to 8PM ET

1 PATIENT AND 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: _____

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 INSURANCE INFORMATION ☐ No insurance

Primary Medical Insurance Name: _____

Policy #: _____ Group #: _____ Phone #: _____

Policy Holder's Full Name: _____

Date of Birth (MM/DD/YYYY): _____ Relationship to Patient: _____

Prescription Drug Insurance Name: _____ Rx Phone #: _____

Rx Group #: _____ Rx PCN #: _____ Rx BIN #: _____

Secondary Medical Insurance Name: _____

Policy #: _____ Group #: _____ Phone #: _____

Policy Holder's Full Name: _____

Date of Birth (MM/DD/YYYY): _____ Relationship to Patient: _____

Prescription Drug Insurance Name: _____ Rx Phone #: _____

Rx Group #: _____ Rx PCN #: _____ Rx BIN #: _____

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

CARE TEAM ROLE	HEALTHCARE PROVIDER OFFICE	NAME	OFFICE PHONE/FAX
Pediatrician			
Primary Care or General Practitioner			
Neurologist			
Gastroenterologist			
Geneticists/Genetic Physician			
Other Healthcare Providers			

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

4 PRESCRIBER INFORMATION

Prescriber First Name: _____ Last Name: _____

Prescriber Specialty: _____ Practice Name: _____

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

NPI #: _____ Medical Provider ID #: _____ DEA #: _____

Phone #: _____ Fax #: _____

Office Contact: _____ Contact Phone #: _____ Office Email: _____

5 CLINICAL INFORMATION

Applicable ICD-10 Code: _____ Has the Patient Had Genetic Testing? ☐ Yes ☐ No Date of Test: _____
(methyl-CpG binding protein 2 [*MECP2*])

Genetic Test Company: _____

Genetic Test Results: _____

Does the patient have renal impairment? Check ☐ Yes ☐ No Current eGFR level: _____

6 PHARMACY PRESCRIPTION

Drug: DAYBUE® (trofinetide) 200 mg/mL, Oral Solution Prescribing Directions: Take _____ mL Twice Daily Day Supply: _____ Refills: _____

Patient's Weight (kg): _____ Administration: ☐ Oral ☐ Gastrostomy Tube Type: ☐ NeoMed® Oral Dispenser ☐ ENFit® ☐ Luer Lock Syringe

Additional Prescribing Directions: _____

Patient's Allergies: ☐ NKDA Please List: _____

Current Medications: _____

In their monthly shipments, all patients will receive ancillary materials required for the treatment method selected by the prescriber.

7 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 DAYBUE that I have elected to prescribe. I direct Acadia to convey, on my behalf, any prescription-related PHI and other prescribing information delivered to Acadia for DAYBUE to the dispensing pharmacy chosen by or for the patient, to the patient's health insurance company, and to other third parties as may be necessary for dispensing the patient's prescription for DAYBUE, with verifying the patient's insurance coverage for DAYBUE, providing information regarding payer coverage and benefits and how to prepare prior authorization requests, coverage determination appeals, or other coverage issues, and/or assisting with patient assistance and support or reduced-cost DAYBUE. 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 DAYBUE, including but not limited to via email, fax, and telephone. I appoint Acadia as my agent for the purpose of conveying this prescription to the appropriate dispensing pharmacy. I certify that DAYBUE is medically necessary and in the best interest of the named patient.

My signature below certifies that I have read, understand, and agree to the Prescriber Authorization statement above.

Sign Here Signature (Dispense as Written): _____ Date: _____
No Stamp Signature

OR

Sign Here Signature (Substitution Allowed): _____ Date: _____
No Stamp Signature

Print Name: _____

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

8 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			
Other Healthcare Providers			

9 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.

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

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

(Please read and sign below if you agree.)

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: _____

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

9 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: _____

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

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

ACADIA®