NUPLAZID®
(pimavanserin) 34mg capsules

Treatment & Service Request Form

acadia connect®
Patient & Caregiver Support

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

Please complete and fax to **1-844-737-2224**, email to **nuplazid@acadiaconnect.com**, or complete the online form at acadiaconnect.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. See Indication and Important Safety Information, including **Boxed WARNING**, on page 3. Please read accompanying full Prescribing Information, also available at NUPLAZIDhcp.com.

1 PATIENT/RESIDENT INFORMATION & INSURANCE

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

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

*Patient resides: ☐ At home ☐ Assisted living ☐ Skilled nursing facility/nursing home

LONG TERM CARE FACILITIES If "Assisted living" or "Skilled nursing facility/nursing home" is selected, please complete the information below. Skip Section 3 if not needed for resident.

*Facility name		*Facility phone number	
Address	City	State	ZIP
Facility contact name		Job title	
Pharmacy name	Pharmacy 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 DIAGNOSIS/PRESCRIBER INFORMATION

***Confirmation of diagnosis required** ☐ Hallucinations and delusions associated with Parkinson's disease psychosis (PDP). ☐ Other diagnosis:_____	***Please confirm dose:** ☐ 34 mg capsule ☐ Other:_____

*Prescriber first and last name	*Prescriber NPI number	State license number (If available)	
Practice/Facility name	*Address		
Primary contact name	*City	*State	*ZIP
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 signature (No stamp allowed) *Date

3 PRESCRIPTION INFORMATION

Skip this section if NUPLAZID® (pimavanserin) order is on file for long term care resident.

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

NUPLAZID® (pimavanserin) ONGOING PRESCRIPTION If marking checkbox for ongoing prescription already sent to pharmacy or prefer to e-prescribe, skip prescription fields.

☐ Already provided prescription to _____ (pharmacy name) | ☐ Will e-prescribe once Acadia Connect confirms appropriate pharmacy

☐ Refills (# of refills): _____ | ☐ sig. Take 34 mg capsule orally, once daily ☐ Dispense: 30-day supply ☐ Other† _____ # of days to be dispensed: _____

Dispense as written 》_____ *Prescriber signature Date

Substitution permitted 》_____ Prescriber signature Date

FREE 14-DAY SUPPLY OF NUPLAZID® (pimavanserin) Note: Limited to a 14-day supply per fill **(only for patients diagnosed with hallucinations and delusions associated with PDP)**

☐ E-prescription already sent to RareMed Pharmacy | 14-day supply with 1 refill ☐ sig. Take 34 mg capsule orally, once daily ☐ Other† _____

Acadia Connect® may send a second Free 14-Day Supply if extra time is needed. 》_____ _____

*Prescriber signature Date

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

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

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

I hereby authorize and direct my 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 Protected Health Information ("PHI") and/or disclose it to Acadia Pharmaceuticals Inc. and its representatives and agents (collectively "Acadia") to assist with my obtaining NUPLAZID 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, my name, address, phone number, and other contact information; information relating to my 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 me, 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 obtaining NUPLAZID and/or participating in the Program, including communicating with me 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 Providers for Program purposes any information about me that Acadia may create or receive.

I understand that once my PHI or other information about me 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 I receive from my Providers, nor will it affect my enrollment or eligibility for health insurance benefits to which I am otherwise entitled. However, if I refuse to sign this authorization, I will not be able to participate in the Program, as the disclosures of my PHI and other information about me by my Providers and Acadia for Program purposes are necessary to facilitate my 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, PO Box 15713, Pittsburgh, PA 15244; 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 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, PO Box 15713, Pittsburgh, PA 15244.

» *_Sign Here_ Patient/Parent/Legal Guardian: _____ *Date _____

Name: _____ Relationship to Patient: _____

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

I agree to enroll in Acadia Connect and, if I am eligible, I agree to enroll in the Acadia Copay Card Program. I understand that any assistance with my cost-sharing or co-payment for NUPLAZID will be made in accordance with the Program Terms and Conditions at https://www.acadiaconnect.com/nuplazid/patient-caregivers.

I also agree that Acadia may collect and process health information about me, including the details I provided on this form, information about my participation in the Program, and other health information about me, such as my diagnosis, symptoms, medication, and inferences derived from the same, to facilitate my participation in the Program, including to investigate insurance benefits, eligibility, and coverage; 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 participation in the Program.

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

If I consent, I have the right to withdraw my consent at any time by calling 844-737-2223 or mailing Acadia Connect, PO Box 15713, Pittsburgh, PA 15244. For more information about Acadia's privacy practices, go to www.acadia.com/privacy. For additional privacy disclosures for California residents, go to https://acadia.com/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, 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.

☐ 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 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 me from Acadia.

Authorized Representative(s) (please print): _____

Name: _____ Relationship to Patient: _____

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

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.**

- **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.

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