

INSTRUCTIONS

To be completed in full, signed, and dated, then faxed to 1-844-394-7155.
 For additional assistance, call 1-84-INGREZZA (1-844-647-3992), 8 AM – 8 PM ET, M – F.

Completion of this form does not initiate treatment but is intended to request access and reimbursement services. Do not submit prescription.
 Please complete and fax the Service Request Form to 1-844-394-7155.

*Indicates required field.

1 SERVICES NEEDED To be completed by prescribing physician, nurse, or facility pharmacist.

*Please select the services needed (check all that apply): Perform a benefits investigation Prior authorization or appeals support

2 RESIDENT/PATIENT INFORMATION
INSURANCE INFORMATION

*Name _____ *DOB (MM/DD/YYYY) _____ Gender _____

*Phone number _____ *Zip code _____

*Caregiver name _____ Caregiver email _____

*Facility point of contact:

*Name _____

*Email _____ *Phone number _____

Section required if resident/patient has insurance Resident/patient does not have insurance
 A copy of resident's face sheet can be provided instead of completing this section. Resident's face sheet provided

*Prescription drug plan _____ *Phone number _____

*Member ID _____ Plan number _____

Cardholder name _____ Group number _____

Relationship to cardholder _____ BIN _____ PCN _____

Medicare beneficiary ID number _____ Last 4 digits of SSN _____

Resident/Patient/Authorized Representative Signature _____

Date: _____

By signing here, I authorize the use and disclosure of my PHI as set forth in the HIPAA Authorization on page 2.

*Description of authorized representative's authority _____

*Resides at: Skilled nursing facility/nursing home Assisted living Not a long-term care resident (If your patient is not a resident, skip to section 3)

*Facility name _____ *Facility address _____

*Facility email _____ *Facility phone number _____ *Facility fax number _____ *City _____ *State _____ *Zip _____

Preferred time and day to be contacted _____ *Pharmacy name _____ *Pharmacy phone # _____ Pharmacy fax # _____

Check if your facility/pharmacy uses CoverMyMeds®

Check this box if your resident is currently covered under Medicare Part A; expected discharge date: _____

3 CLINICAL INFORMATION

Treatment decision has been made by, or in consultation with: Psychiatrist/Psych NP Name: _____ NPI: _____ Neurologist Name: _____ NPI: _____

*Primary diagnosis (ICD-10 code): Tardive dyskinesia (G24.01) Huntington's chorea (G10) Other diagnosis (ICD-10 code) _____

Check one box within Initial Dose and one box within Maintenance Dose. NOTE: For access and reimbursement services only; not a valid Rx.^a

INITIAL Dose*	MAINTENANCE Dose*
<input type="checkbox"/> 40 mg once daily × 7 (tardive dyskinesia)	<input type="checkbox"/> 40 mg once daily, 1-month supply
<input type="checkbox"/> 40 mg once daily × 14 then 60 mg once daily × 14 (Huntington's chorea)	<input type="checkbox"/> 60 mg once daily, 1-month supply
No refills	<input type="checkbox"/> 80 mg once daily, 1-month supply
<input type="checkbox"/> Other ^b : _____	Refills # _____

^aThe dosage selection is for purposes of ensuring accuracy of information needed for reimbursement and coverage for INGREZZA through the resident's health insurance plan. Selecting a dosage option does not constitute a valid prescription for INGREZZA; this form will not be triaged to a pharmacy.

^bIf in-office samples were used, you may select Maintenance Rx only.

Prescriber Authorization: I certify that the information provided in this INGREZZA® (valbenazine) capsules Service Request Form is complete and accurate to the best of my knowledge, any prescribing decisions are based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that, where required by federal and/or state law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc., and its agents and pharmacies, including but not limited to the INBRACE Support Program. I direct the INBRACE Support Program to convey, on my behalf, any treatment information about INGREZZA to the patient's health insurance company, to the dispensing pharmacy chosen by or for the patient, or to other third parties as may be necessary to assist this patient with securing any insurance coverage for INGREZZA to which the patient is entitled or with filling a prescription for INGREZZA.

Prescriber or authorized agent name: _____ *Prescriber NPI: _____

Prescriber phone number: _____ Prescriber fax number: _____

*Prescriber Signature _____

*Date: _____

PATIENT HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Neurocrine, companies working with Neurocrine, my healthcare provider and pharmacy to use and disclose to Neurocrine, and companies working with Neurocrine, my Protected Health Information (“PHI”), such as information provided on the INGREZZA Service Request Form, my prescription, insurance, medical therapy information and other PHI for the following purposes: (1) providing financial assistance options, (2) reimbursement support, (3) medication compliance and persistence, (4) information about Neurocrine products and programs, which may from time to time include requests to participate in market research or other initiatives related to my experiences with my condition and/or INGREZZA, and (5) other treatment-related services, including providing information and materials related to the INBRACE Support Program (collectively called “Support Services”). I authorize the disclosure of my PHI to communicate with the point of contact in Section 2 of the Service Request Form. I understand that the companies working with Neurocrine, including my pharmacy, may receive payment for the use and disclosure of my PHI. I understand that once it is disclosed, it may be re-disclosed by the recipient(s). After such a disclosure, the information may no longer be protected by HIPAA or the terms of this authorization against further re-disclosure. I understand that this authorization shall continue in effect for a period of ten years unless a shorter period is required by law. I understand that I may revoke this authorization to use or disclose my PHI by contacting an INBRACE Support Program representative by telephone (1-844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130. I understand that my healthcare provider, pharmacy, and/or Neurocrine will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Neurocrine will not be able to help me with Support Services as described above. I may obtain a copy of this Authorization upon request.

For the Neurocrine Biosciences, Inc. Privacy Policy, please visit www.neurocrine.com/about-us/privacy-policy/