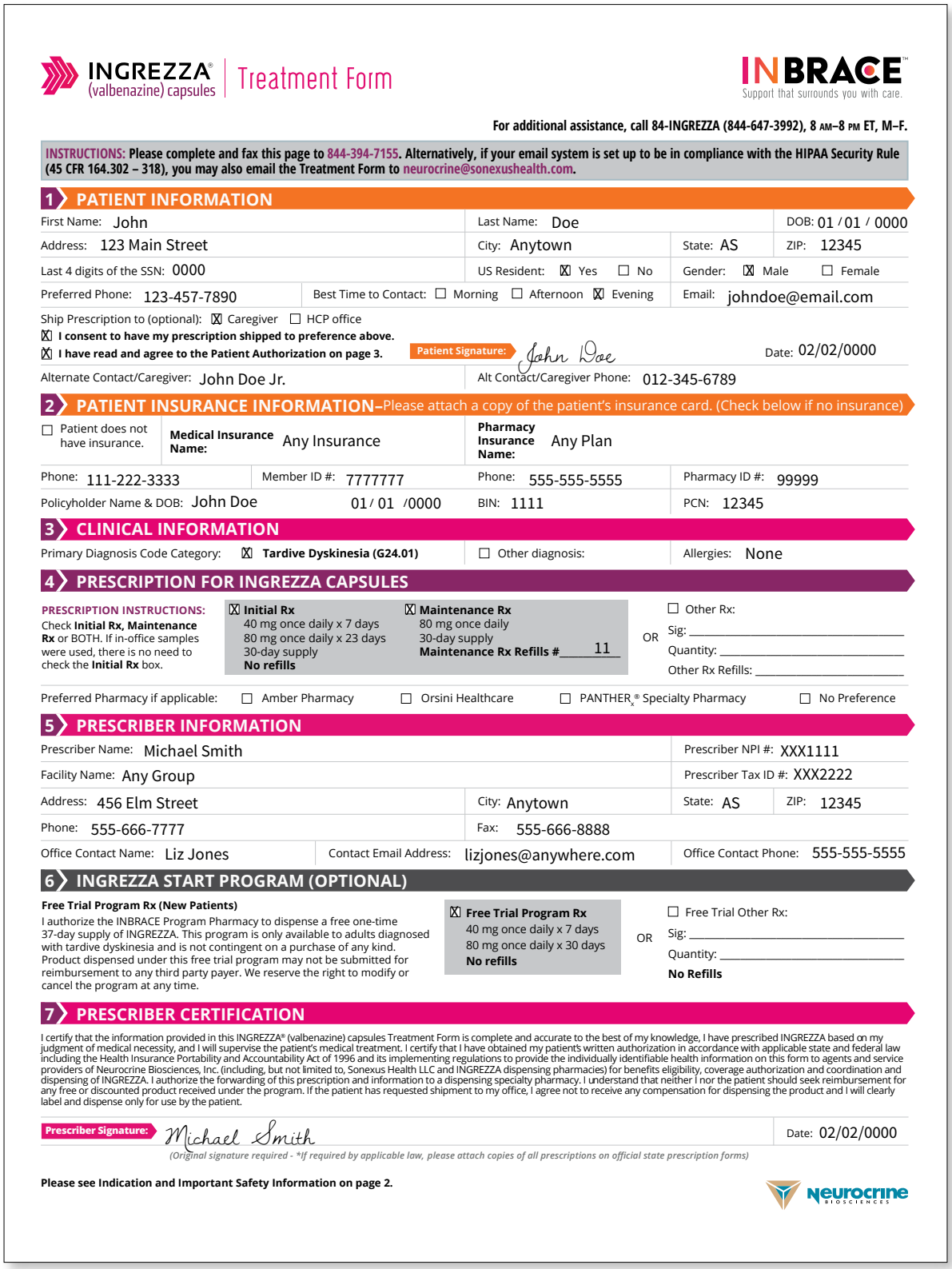
Completing the INGREZZA® (valbenazine) capsules Treatment Form: **A Step-by-Step Guide**



INGREZZA® (valbenazine) capsules | Treatment Form

INBRACE™ Support that surrounds you with care.

For additional assistance, call 84-INGREZZA (844-647-3992), 8 AM–8 PM ET, M–F.

INSTRUCTIONS: Please complete and fax this page to 844-394-7155. Alternatively, if your email system is set up to be in compliance with the HIPAA Security Rule (45 CFR 164.302 – 318), you may also email the Treatment Form to neurocrine@sonexushealth.com.

1 PATIENT INFORMATION

First Name: John | Last Name: Doe | DOB: 01 / 01 / 0000

Address: 123 Main Street | City: Anytown | State: AS | ZIP: 12345

Last 4 digits of the SSN: 0000 | US Resident: ☒ Yes ☐ No | Gender: ☒ Male ☐ Female

Preferred Phone: 123-457-7890 | Best Time to Contact: ☐ Morning ☐ Afternoon ☒ Evening | Email: johndoe@email.com

Ship Prescription to (optional): ☒ Caregiver ☐ HCP office

☒ **I consent to have my prescription shipped to preference above.**

☒ **I have read and agree to the Patient Authorization on page 3.**

Patient Signature: John Doe | Date: 02/02/0000

Alternate Contact/Caregiver: John Doe Jr. | Alt Contact/Caregiver Phone: 012-345-6789

2 PATIENT INSURANCE INFORMATION–Please attach a copy of the patient's insurance card. (Check below if no insurance)

☐ Patient does not have insurance.

Medical Insurance Name: Any Insurance | Phone: 111-222-3333 | Member ID #: 7777777

Pharmacy Insurance Name: Any Plan | Phone: 555-555-5555 | Pharmacy ID #: 99999

Policyholder Name & DOB: John Doe 01 / 01 /0000 | BIN: 1111 | PCN: 12345

3 CLINICAL INFORMATION

Primary Diagnosis Code Category: ☒ **Tardive Dyskinesia (G24.01)** ☐ Other diagnosis: | Allergies: None

4 PRESCRIPTION FOR INGREZZA CAPSULES

PRESCRIPTION INSTRUCTIONS: Check **Initial Rx, Maintenance Rx** or BOTH. If in-office samples were used, there is no need to check the **Initial Rx** box.

☒ **Initial Rx**
40 mg once daily x 7 days
80 mg once daily x 23 days
30-day supply
No refills

☒ **Maintenance Rx**
80 mg once daily
30-day supply
Maintenance Rx Refills # 11

OR

☐ Other Rx:
Sig: _____
Quantity: _____
Other Rx Refills: _____

Preferred Pharmacy if applicable: ☐ Amber Pharmacy ☐ Orsini Healthcare ☐ PANTHERx® Specialty Pharmacy ☐ No Preference

5 PRESCRIBER INFORMATION

Prescriber Name: Michael Smith | Prescriber NPI #: XXX1111

Facility Name: Any Group | Prescriber Tax ID #: XXX2222

Address: 456 Elm Street | City: Anytown | State: AS | ZIP: 12345

Phone: 555-666-7777 | Fax: 555-666-8888

Office Contact Name: Liz Jones | Contact Email Address: lizjones@anywhere.com | Office Contact Phone: 555-555-5555

6 INGREZZA START PROGRAM (OPTIONAL)

Free Trial Program Rx (New Patients)

I authorize the INBRACE Program Pharmacy to dispense a free one-time 37-day supply of INGREZZA. This program is only available to adults diagnosed with tardive dyskinesia and is not contingent on a purchase of any kind. Product dispensed under this free trial program may not be submitted for reimbursement to any third party payer. We reserve the right to modify or cancel the program at any time.

☒ **Free Trial Program Rx**
40 mg once daily x 7 days
80 mg once daily x 30 days
No refills

OR

☐ Free Trial Other Rx:
Sig: _____
Quantity: _____
No Refills

7 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Treatment Form is complete and accurate to the best of my knowledge, I have prescribed INGREZZA based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Neurocrine Biosciences, Inc. (including, but not limited to, Sonexus Health LLC and INGREZZA dispensing pharmacies) for benefits eligibility, coverage authorization and coordination and dispensing of INGREZZA. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program. If the patient has requested shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient.

Prescriber Signature: Michael Smith | Date: 02/02/0000

*(Original signature required - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*

Please see Indication and Important Safety Information on page 2.

Neurocrine Biosciences

Please see Indication and Important Safety Information on last page and accompanying full Prescribing Information.

How to Complete the INGREZZA® (valbenazine) capsules Treatment Form

Quick Reminders

The INGREZZA Treatment Form enrolls patients into the INBRACE® Support Program and is also their prescription for INGREZZA

- Make sure that you sign and date the form
- Fax the completed Treatment Form to 844-394-7155
- Have the patient check the appropriate boxes and then sign and date the form

INGREZZA® (valbenazine) capsules | Treatment Form

INBRACE™ Support that surrounds you with care.

For additional assistance, call 84-INGREZZA (844-647-3992), 8 AM–8 PM ET, M–F.

INSTRUCTIONS: Please complete and fax this page to 844-394-7155. Alternatively, if your email system is set up to be in compliance with the HIPAA Security Rule (45 CFR 164.302 – 318), you may also email the Treatment Form to neurocrine@sonexushealth.com.

1 PATIENT INFORMATION

First Name: John	Last Name: Doe		DOB: 01 / 01 / 0000
Address: 123 Main Street	City: Anytown	State: AS	ZIP: 12345
Last 4 digits of the SSN: 0000	US Resident: ☒ Yes ☐ No	Gender: ☒ Male ☐ Female	
Preferred Phone: 123-457-7890	Best Time to Contact: ☐ Morning ☐ Afternoon ☒ Evening	Email: johndoe@email.com	

Ship Prescription to (optional): ☒ Caregiver ☐ HCP office

☒ **I consent to have my prescription shipped to preference above.**

☒ **I have read and agree to the Patient Authorization on page 3.**

Patient Signature: John Doe Date: 02/02/0000

Alternate Contact/Caregiver: John Doe Jr. | Alt Contact/Caregiver Phone: 012-345-6789

The Treatment Form contains fillable fields.

- The patient name, address, date of birth, telephone number, last 4 digits of the Social Security Number, and additional information are required
- Check where INGREZZA should be shipped
- **NOTE: Obtain patient or legal authorized representative signature and date***

*We cannot contact a caregiver or send information without the patient or authorized representative checking the box and signing and dating the form indicating they have read and agree to the Patient Authorization on page 3.

2 PATIENT INSURANCE INFORMATION–Please attach a copy of the patient's insurance card. (Check below if no insurance)

☐ Patient does not have insurance.	**Medical Insurance Name:** Any Insurance	**Pharmacy Insurance Name:** Any Plan	
Phone: 111-222-3333	Member ID #: 7777777	Phone: 555-555-5555	Pharmacy ID #: 99999
Policyholder Name & DOB: John Doe 01 / 01 /0000		BIN: 1111	PCN: 12345

Provide a copy of the front/back of insurance card(s) or complete this section.

- If the patient has **no insurance**, check the first box
- If the patient has both medical and pharmacy coverage, provide information for both plans

3 CLINICAL INFORMATION

Primary Diagnosis Code Category: ☒ **Tardive Dyskinesia (G24.01)**	☐ Other diagnosis:	Allergies: None

This section must be completed by the treatment provider.

- The information is necessary to validate FDA approved use of INGREZZA, as well as for completion of the benefit investigation process

Please see Indication and Important Safety Information on last page and accompanying full Prescribing Information.

4 PRESCRIPTION FOR INGREZZA CAPSULES

PRESCRIPTION INSTRUCTIONS:
Check **Initial Rx, Maintenance Rx** or BOTH. If in-office samples were used, there is no need to check the **Initial Rx** box.

☒ **Initial Rx**
40 mg once daily x 7 days
80 mg once daily x 23 days
30-day supply
No refills

☒ **Maintenance Rx**
80 mg once daily
30-day supply
Maintenance Rx Refills # 11

OR

☐ Other Rx:
Sig: _____
Quantity: _____
Other Rx Refills: _____

Preferred Pharmacy if applicable: ☐ Amber Pharmacy ☐ Orsini Healthcare ☐ PANTHERx® Specialty Pharmacy ☐ No Preference

This section of the form is the prescription for INGREZZA.

- Check boxes for Initial Rx (30-day supply, no refills) and/or Maintenance Rx (including number of refills)
- Optional: Check the appropriate box to indicate a preferred pharmacy if applicable

5 PRESCRIBER INFORMATION

Prescriber Name: Michael Smith			Prescriber NPI #: XXX1111
Facility Name: Any Group			Prescriber Tax ID #: XXX2222
Address: 456 Elm Street	City: Anytown	State: AS	ZIP: 12345
Phone: 555-666-7777	Fax: 555-666-8888		
Office Contact Name: Liz Jones	Contact Email Address: lizjones@anywhere.com		Office Contact Phone: 555-555-5555

Prescriber contact information is required for enrollment purposes.

- Prescriber contact information is important in case the INBRACE Support Program or specialty pharmacy must contact the office for additional information
- List the person/phone number at the office who is responsible for managing the patient's information (benefits, prior authorizations, etc)

6 INGREZZA START PROGRAM (OPTIONAL)

Free Trial Program Rx (New Patients)
I authorize the INBRACE Program Pharmacy to dispense a free one-time 37-day supply of INGREZZA. This program is only available to adults diagnosed with tardive dyskinesia and is not contingent on a purchase of any kind. Product dispensed under this free trial program may not be submitted for reimbursement to any third party payer. We reserve the right to modify or cancel the program at any time.

☒ **Free Trial Program Rx**
40 mg once daily x 7 days
80 mg once daily x 30 days
No refills

OR

☐ Free Trial Other Rx:
Sig: _____
Quantity: _____
No Refills

This section must be completed to enroll patients in the INGREZZA Start Program.

- New patients may receive a one-time 37-day supply of INGREZZA by completing this section
- The INGREZZA Start Program is not contingent on a purchase of any kind and this section of the form can be completed to request only the Free Trial

7 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Treatment Form is complete and accurate to the best of my knowledge, I have prescribed INGREZZA based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Neurocrine Biosciences, Inc. (including, but not limited to, Sonexus Health LLC and INGREZZA dispensing pharmacies) for benefits eligibility, coverage authorization and coordination and dispensing of INGREZZA. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program. If the patient has requested shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient.

Prescriber Signature: Michael Smith Date: 02/02/0000

*(Original signature required - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*

Please see Indication and Important Safety Information on page 2.

Neurocrine Biosciences

Healthcare provider signature and date are required here.

For questions, call 84-INGREZZA (844-647-3992), 8 AM to 8 PM ET, Monday through Friday.

Please see Indication and Important Safety Information on last page and accompanying full Prescribing Information.

PATIENT SERVICES/OTHER COMMUNICATIONS

Patient Authorization

Program Opt-In

I authorize Neurocrine, and companies working with Neurocrine, to provide me with support services related to Neurocrine products, marketing materials, information about Neurocrine products, services, and programs or other topics of interest, conduct market research or otherwise ask me about my experience with or thoughts about such topics. Services may also include, but are not limited to: online support, financial assistance services, reimbursement support, medication compliance and persistence, and other treatment related services, as well as any information or materials related to such services (collectively called "Support Services"). I agree and acknowledge that any nurse or other person providing Support Services is not employed by my healthcare professional. I authorize Neurocrine, and companies working with Neurocrine, to contact me to provide Support Services and information by mail, e-mail, fax, telephone call, text message, and other means. I understand that I do not have to agree to receive the Support Services and that I can still receive INGREZZA, as prescribed by my physician. I understand that I am under no obligation to purchase INGREZZA, whether or not I have started INGREZZA under a free trial program offered by Neurocrine. I understand that I cannot seek reimbursement from any health insurance or third party, including state or federally funded programs, for free trial product nor can it be counted towards my true out-of-pocket costs. I certify that I am at least eighteen (18) years of age. I understand that I may opt-out of receiving the Support Services by notifying an INBRACE Support Program representative by telephone (844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130.

Authorization for Use and Disclosure of Protected Health Information

I also 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 Treatment Form, my prescription, insurance, medical therapy information and other PHI in connection with the Support Services as described above. I authorize the disclosure of my PHI to specific individuals who are identified on the INGREZZA Treatment 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 I do not have to agree to the use and disclosure of my PHI in order to receive INGREZZA, but without this authorization I may not be able to receive the Support Services. While my PHI will be protected and used and disclosed only for the intended purposes, 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 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 (844-647-3992) or by mailing a letter to Neurocrine, Attn: INBRACE Support Program, 12780 El Camino Real, San Diego, CA 92130.

- The purpose of this section is to inform the patient about how and to whom information may be shared, for what purposes the information may be shared, that the information cannot be further disclosed by the entities that receive it, and explain that the authorization is voluntary and can be revoked at any time
- You may tear off the back page of this form in order to provide a copy to the patient

IMPORTANT INFORMATION

INDICATION & USAGE

INGREZZA® (valbenazine) capsules is indicated for the treatment of adults with tardive dyskinesia.

IMPORTANT SAFETY INFORMATION

WARNINGS & PRECAUTIONS

Somnolence

INGREZZA can cause somnolence. Patients should not perform activities requiring mental alertness such as operating a motor vehicle or operating hazardous machinery until they know how they will be affected by INGREZZA.

QT Prolongation

INGREZZA may prolong the QT interval, although the degree of QT prolongation is not clinically significant at concentrations expected with recommended dosing. INGREZZA should be avoided in patients with congenital long QT syndrome or with arrhythmias associated with a prolonged QT interval. For patients at increased risk of a prolonged QT interval, assess the QT interval before increasing the dosage.

ADVERSE REACTIONS

The most common adverse reaction (≥5% and twice the rate of placebo) is somnolence. Other adverse reactions (≥2% and >placebo) include: anticholinergic effects, balance disorders/falls, headache, akathisia, vomiting, nausea, and arthralgia.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit MedWatch at www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see accompanying INGREZZA full Prescribing Information or visit www.INGREZZAHCP.com

Neurocrine BIOSCIENCES

 CP-VBZ-US-0677 06/18

INGREZZA® (valbenazine) capsules