INGREZZA® (valbenazine) capsules

PATIENT ASSISTANCE PROGRAM

INBRACE™ Support that surrounds you with care.

APPLICATION

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

- Only completed INGREZZA Patient Assistance Program Applications will be reviewed for patient program eligibility. Please ensure all areas of the form are completed in full with all signatures.
- Applicants must reside in the continental US or its territories, meet the program financial requirements, and must not have prescription coverage for INGREZZA in order to qualify. Each applicant will be assessed for individual program eligibility upon receipt of this completed INGREZZA Patient Assistance Program Application.

1 PATIENT INFORMATION

First Name:	Last Name:		DOB: / /
Address:	City:	State:	ZIP:
Last 4 digits of the SSN:	US Resident: Yes ☐ No ☐	Gender: Male ☐ Female ☐	
Preferred Phone:	Best Time to Contact: Morning ☐ Afternoon ☐ Evening ☐	Email:	
Alternate Contact/Caregiver:	Alt Contact/Caregiver Phone:		

☐ For 2 years, unless revoked in writing, I authorize Sonexus Health, LLC to use and disclose my health information contained in this application to individuals listed above for the purpose of coordinating prescription fulfillment and financial assistance. *(Optional)*

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:** Date:

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:**	**Pharmacy Insurance Name:**	
Phone:	Member ID #:	Phone:	Pharmacy ID #:
Policyholder Name & DOB: / /		BIN:	PCN:

3 FINANCIAL INFORMATION

Total Monthly Gross Household Income: $ | Household Size (select one): 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Select Your Sources of Income: Salary/Wages ☐ SS Pension/Unemployment ☐ Alimony/Child Support ☐ Retirement ☐ SSDI ☐ SSI ☐

No Household Income ☐ Other ☐: _____

Income subject to verification

4 CLINICAL INFORMATION

Primary Diagnosis Code Category: ☐ **Tardive Dyskinesia (G24.01)**	☐ Other diagnosis:	Allergies:

5 PRESCRIBER INFORMATION

Prescriber Name:		Prescriber NPI #:	
Facility Name:		Prescriber Tax ID #:	
Address:	City:	State:	ZIP:
Phone:	Fax:		
Office Contact Name:	Contact Email Address:	Office Contact Phone:	

6 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 #_____

OR

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

7 PRESCRIBER CERTIFICATION

I certify that the information provided in this INGREZZA® (valbenazine) capsules Patient Assistance Program Application 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 the INBRACE Support Program Pharmacy. I understand that neither I nor the patient should seek reimbursement for any free or discounted product received under the program.

Prescriber Signature: Date:

*(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

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.INGREZZA.com/HCP

PATIENT AUTHORIZATION FOR ELECTRONIC FINANCIAL SCREENING

I understand that I am providing "written instructions" to Neurocrine Biosciences, Inc. and its vendor Sonexus Health, LLC under the Fair Credit Reporting Act authorizing Sonexus Health, LLC on behalf of Neurocrine Biosciences, Inc. to obtain information from my credit profile or other information from Experian Health. I authorize Neurocrine Biosciences and its partnered provider Sonexus Health to obtain such information solely for the purpose of determining financial qualifications for the INGREZZA Patient Assistance Program (PAP). I understand that I must affirmatively agree to the terms in this notice in order to proceed in the PAP financial screening process. I understand that I am entitled to a copy of this Authorization upon request. This Authorization shall be valid for 2 years from the date of signature (unless a shorter period is prescribed by state law). I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to INGREZZA Patient Assistance Program, c/o Sonexus Health 1330 Enclave Parkway, Ste. 125 Houston, TX 77077, but that this cancellation will not apply to any information already used or disclosed through this Authorization. My signature certifies that I have read and understand the above statements, and agree to the outlined terms.